

c. Treatment for heart failure

8. Was cardiac imaging performed prior to this hospitalization?

Yes No/Unk

Go to item 9.

8. a. Lowest Ejection Fraction recorded: %

8. a.1. Qualitative description:

- Normal..... N
- Decreased mildly..... D
- Decreased moderately.....M
- Decreased severely..... S
- None of the above.....O

8. b. Year of lowest ejection fraction (yyyy)

8.c. Type of imaging:

- 1. MUGA
- 2. ECHO
- 3. Cath/LV gram
- 4. CT
- 5. MRI
- 6. Other
- 7. Unknown

SECTION III: MEDICAL HISTORY AND PRECIPITATING FACTORS

9. General

History of?
Yes No/NR

- | | | |
|-----------------------------------|--------------------------|--------------------------|
| a. AIDS/HIV | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Excess alcohol use | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Illicit drug use | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Cancer (excluding skin cancer) | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Connective tissue disease | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Ex-smoker | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Current smoker | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Thyroid disease | <input type="checkbox"/> | <input type="checkbox"/> |

Respiratory

- | | | |
|--|--------------------------|--------------------------|
| a. Asthma ^G | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Chronic bronchitis/COPD ^G | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Other chronic lung disease | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Pulmonary embolus | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Coughing, phlegm, wheezing ^G | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Sleep apnea | <input type="checkbox"/> | <input type="checkbox"/> |

11. Cardiovascular

- | | | |
|--|--------------------------|--------------------------|
| a. Angina ^G | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Arrhythmia | | |
| 1) Atrial fibrillation/atrial flutter | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Heart block or other bradycardia | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Ventricular fibrillation or tachycardia | <input type="checkbox"/> | <input type="checkbox"/> |

SECTION III: MEDICAL HISTORY AND PRECIPITATING FACTORS (continued)

11. Cardiovascular (continued)

History of?
Yes No/NR

- | | | |
|--------------------------------------|--------------------------|--------------------------|
| c. Infectious/bacterial endocarditis | <input type="checkbox"/> | <input type="checkbox"/> |
| d. cardiac arrest | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Cardiac procedures | <input type="checkbox"/> | <input type="checkbox"/> |
| a. CABG | <input type="checkbox"/> | <input type="checkbox"/> |
| b. PCI | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Valve surgery | <input type="checkbox"/> | <input type="checkbox"/> |

- d. Pacemaker
- e. Defibrillator
- f. Congenital heart disease
- g. Coronary heart disease (within year) ^G
- h. Coronary heart disease (ever) ^G
- i. Electrocardioversion/defibrillation
- j. Hypertension
- k. Myocardial infarction
- l. Pulmonary hypertension
- m. Peripheral vascular disease
- n. Rheumatic heart disease
- o. Valvular heart disease

If Yes, go to item 11.i.

12. Gastrointestinal / Endocrine

- a. Diabetes
- b. Hyperlipidemia
- c. Liver disease

13. Renal

- a. Dialysis

SECTION III: MEDICAL HISTORY AND PRECIPITATING FACTORS (continued)

14. Neurology

History of?
Yes No/NR

- a. Stroke/TIA
- b. Depression

15. Other significant medical condition: _____

16. Were any of the following medical problems listed as precipitating factors (i.e. precipitated the onset of this event)?

Yes No/NR

- a. Postpartum state
- b. Excess alcohol intake
- c. Excess fluid intake/administration
- d. Noncompliance with diet
- e. Noncompliance with medication
- f. Infection
- g. Pneumonia

h. Infectious/ bacterial endocarditis

i. Pulmonary embolus

j. Angina

k. Atrial fibrillation/flutter

l. Heart block

m. Ventricular fibrillation/flutter

n. Cardiac arrest

o. Myocardial infarction

p. Valvular heart disease

q. Stroke/TIA

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

SECTION IV: PHYSICAL EXAM - VITAL SIGNS

	At hospital admission (or at onset of event)	At hospital discharge (or last recorded)
17. Blood pressure:	a. <input type="text"/> <input type="text"/> <input type="text"/> / b. <input type="text"/> <input type="text"/> <input type="text"/> mmHg	c. <input type="text"/> <input type="text"/> <input type="text"/> / d. <input type="text"/> <input type="text"/> <input type="text"/>
18. Heart rate: ^{B, F, N}	a. <input type="text"/> <input type="text"/> <input type="text"/> bpm	
19. Height:	a. <input type="text"/> <input type="text"/> <input type="text"/> a.1. <input type="text"/> cm/ in (c=cm, i=in)	
20. Weight: ^F	a. <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> a.1. <input type="text"/> lbs/ kg b. <input type="text"/> <input type="text"/> <input type="text"/> b.1. <input type="text"/> lbs\ kg <input type="text"/>	
	(l=lbs, k=kg)	(l=lbs, k=kg)
21. Respiration rate	<input type="text"/> <input type="text"/> <input type="text"/> /min	<input type="text"/> <input type="text"/> <input type="text"/> /min

SECTION V: PHYSICAL EXAM AND SYMPTOMS - FINDINGS

22. Did the patient have any of the following GENERAL signs or symptoms?

	Anytime during hospitalization or at admission		At hospital discharge	
	Yes	No/NR	Yes	No/NR
	a. Lower extremity edema ^{G, F, N}	<input type="checkbox"/>	<input type="checkbox"/>	a.1. <input type="checkbox"/>
b. Jugular venous distension (JVD) ^{B, F, N}	<input type="checkbox"/>	<input type="checkbox"/>	b.1. <input type="checkbox"/>	<input type="checkbox"/>
c. Hepatojugular reflux ^F	<input type="checkbox"/>	<input type="checkbox"/>		
d. Hepatomegaly ^{F, N, B}	<input type="checkbox"/>	<input type="checkbox"/>		
e. Leg fatigue on walking ^B	<input type="checkbox"/>	<input type="checkbox"/>		

23. Did the patient have any of the following RESPIRATORY signs or symptoms?

	Anytime during hospitalization or at admission		At hospital discharge	
	Yes	No/NR	Yes	No/NR
	a. Cough ^F	<input type="checkbox"/>	<input type="checkbox"/>	a.1. <input type="checkbox"/>
b. Dyspnea (Rest) ^B	<input type="checkbox"/>	<input type="checkbox"/>	b.1. <input type="checkbox"/>	<input type="checkbox"/>
c. Dyspnea (Walking) ^{B, F, N}	<input type="checkbox"/>	<input type="checkbox"/>	c.1. <input type="checkbox"/>	<input type="checkbox"/>
d. Dyspnea (Climbing or exertion) ^{B, F, N}	<input type="checkbox"/>	<input type="checkbox"/>	d.1. <input type="checkbox"/>	<input type="checkbox"/>
e. Stops for breath when walking ^N	<input type="checkbox"/>	<input type="checkbox"/>	e.1. <input type="checkbox"/>	<input type="checkbox"/>
f. Stops for breath after 100 yards ^N	<input type="checkbox"/>	<input type="checkbox"/>		
g. Rhonchi ^G	<input type="checkbox"/>	<input type="checkbox"/>		
h. Paroxysmal nocturnal dyspnea ^{B, F, G}	<input type="checkbox"/>	<input type="checkbox"/>	h.1. <input type="checkbox"/>	<input type="checkbox"/>
i. Orthopnea ^B	<input type="checkbox"/>	<input type="checkbox"/>	i.1. <input type="checkbox"/>	<input type="checkbox"/>
j. Pulmonary basilar rales ^{B, G, F, N}	<input type="checkbox"/>	<input type="checkbox"/>	j.1. <input type="checkbox"/>	<input type="checkbox"/>
k. Rales (more than basilar) ^{B, G, F, N}	<input type="checkbox"/>	<input type="checkbox"/>	k.1. <input type="checkbox"/>	<input type="checkbox"/>
l. Wheezing ^B	<input type="checkbox"/>	<input type="checkbox"/>	l.1. <input type="checkbox"/>	<input type="checkbox"/>
m. Vital capacity (decreased 1/3) ^F	<input type="checkbox"/>	<input type="checkbox"/>		

If Yes, go to item 23g.

SECTION V: PHYSICAL EXAM AND SYMPTOMS - FINDINGS (continued)

24. Did the patient have any of the following CARDIOVASCULAR signs or symptoms?

discharge	Anytime during hospitalization		At hospital	
	<u>Yes</u>	<u>No/NR</u>	<u>Yes</u>	<u>No/NR</u>
a. S3 (gallop) ^{B, F}	<input type="checkbox"/>	<input type="checkbox"/>	a.1. <input type="checkbox"/>	<input type="checkbox"/>
b. S4 (gallop)	<input type="checkbox"/>	<input type="checkbox"/>	b.1. <input type="checkbox"/>	<input type="checkbox"/>
c. Chest Pain ^G	<input type="checkbox"/>	<input type="checkbox"/>	c.1. <input type="checkbox"/>	<input type="checkbox"/>
d. NYHA class: I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> not recorded <input type="checkbox"/>				

SECTION VI: DIAGNOSTIC TESTS

25. Was an electrocardiogram performed during this hospitalization?: Yes /NR → Go to item 27.

26. Did the patient have any of the following ECG abnormalities at any time during this hospitalization?

Yes No/Unknown

- a. MI (age undetermined)
- b. Ischemic changes or ST-T changes
- c. Atrial fibrillation / atrial flutter ^G → c.1. On telemetry? Yes No
- d. Left ventricular hypertrophy
- e. Left bundle branch block
- f. Ventricular tachycardia → f.1. On telemetry? Yes No

27. Was a chest X-ray performed during this hospitalization?: Yes No/NR → Go to item 29.

28. Did the patient have any of the following signs on chest X-ray at any time during this hospitalization?

Yes No/Unknown

- a. Alveolar infiltrates
- b. Alveolar/pulmonary edema ^{B, F, N}
- c. Interstitial pulmonary edema ^{B, F, N}
- d. Cardiomegaly ^{B, F}
- e. Cephalization/upper zone redistribution ^{B, N}
- f. Congestive heart failure
- g. Bilateral pleural effusion ^{B, F, N}
- h. Unilateral pleural effusion ^{F, N}
- i. Pulmonary vascular congestion
- j. Kerley B lines
- k. Cardiothoracic ratio ≥ 0.5 ^B

SECTION VI: DIAGNOSTIC TESTS (continued)

29. Was a transthoracic echocardiogram performed? Yes No/NR Go to item 30

First transthoracic echocardiogram performed after onset or progression of heart failure.

a. Date (mm-dd-yyyy): - -

b. Ejection fraction: %

c. Wall thickness: septal: c.1. unit (1=cm, 2=mm)

c.2. posterior: c.3. units (1=cm, 2=mm)

d. Record the following if present on transthoracic echocardiogram:

	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>	<u>None</u>	<u>Present</u>	<u>NR</u>
1. Left ventricular hypertrophy (LVH)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Impaired LV systolic function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Impaired RV systolic function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Aortic regurgitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Aortic stenosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Tricuspid regurgitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Mitral regurgitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Mitral stenosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Estimated RVSP/PASP:	<input type="text"/> <input type="text"/> <input type="text"/> mmHg		a. TR jet velocity <input type="text"/> <input type="text"/> m/s		<input type="checkbox"/>	<input type="checkbox"/>
10. Pulmonary hypertension	<input type="checkbox"/> <u>Yes</u>	<input type="checkbox"/> <u>No/Unknown/NR</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Regional wall motion abnormality	<input type="checkbox"/>	<input type="checkbox"/>				
12. Dilated left ventricle	<input type="checkbox"/>	<input type="checkbox"/>				
13. Dilated right ventricle	<input type="checkbox"/>	<input type="checkbox"/>				
14. Diastolic dysfunction	<input type="checkbox"/>	<input type="checkbox"/>				

SECTION VI: DIAGNOSTIC TESTS (continued)

30. Was a transesophageal echocardiogram performed? Yes No/NR

Go to item 31.

First transesophageal echocardiogram performed after onset or progression of event.

a. Date (mm-dd-yyyy) - -

b. Ejection fraction: %

c. Record the following if present on transesophageal echocardiogram:

	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>	<u>None</u>	<u>Present</u>	<u>NR</u>
1. Impaired LV systolic function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Impaired RV systolic function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Yes</u>	<u>No/Unknown/NR</u>				
3. Regional wall motion abnormality	<input type="checkbox"/>	<input type="checkbox"/>				
4. Dilated left ventricle	<input type="checkbox"/>	<input type="checkbox"/>				
5. Dilated right ventricle	<input type="checkbox"/>	<input type="checkbox"/>				

SECTION VI: DIAGNOSTIC TESTS (continued)

31 Was a right cardiac catheterization performed? Yes No/NR

Go to item 32.

a. Date (mm-dd-yyyy) : - -

b. Record the following measurements from the catheterization report::

1. Right atrial pressure (mean): mmHg

2. Pulmonary arterial pressure: / mmHg

3. Pulmonary wedge pressure: mmHg

4. Cardiac output: liters/min

5. Cardiac index: liters/min/m² BSA

32. Was coronary angiography performed? Yes No/NR → Go to item 33.

a. Date (mm-dd-yyyy) : --

b. Record the following:

1. Ejection fraction: %

2. Coronary stenosis:

0 1-24 25-49 50-74 75-94 95-99 100 NR
% % % % % % %

a. Left main:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

b. Left anterior descending artery and branches:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

c. Left circumflex/marginal artery:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

d. Right coronary artery and branches:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

e. Intermediate ramus:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

3. Were coronary bypass grafts present? Yes

No/NR → Go to item 32.b.4.

a. Number of occluded grafts:

4. Mitral regurgitation: mild moderate severe none present NR

SECTION VI: DIAGNOSTIC TESTS (continued)

33. Was a cardiac radionuclide ventriculogram performed? Yes No/NR → Go to item 34.

a. Date: --
(mm-dd-yyyy)

b. Ejection fraction: LV % c. RV %

34. Was a cardiac Magnetic Resonance Imaging (MRI) performed? Yes No/NR → Go to item 35.

a. Date: --
(mm-dd-yyyy)

b. Ejection fraction: LV % c. RV %

35. Was a cardiac CT scan performed? Yes No/NR → Go to item 36.

a. Date: --

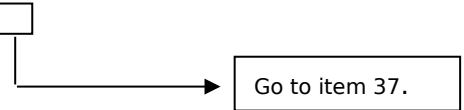
b. Ejection fraction: LV: % c. RV: %

(mm-dd-yyyy)

36. Was a stress test performed?

Yes

No/NR



a. Date: - -

b. Normal Abnormal Equivocal Not diagnostic

c. Ejection fraction: LV: %

SECTION VII: BIOCHEMICAL ANALYSES

	a. <u>Worst*</u>	b. <u>Last</u>	c. <u>Upper Limit Normal</u>
37. Hemoglobin (g/dL)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
38. Hematocrit (%)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
39. BNP (pg/mL)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
40. ProBNP (pg/mL)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
41. Troponin T (ng/mL)	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
42. Troponin I (ng/mL)	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
43. Sodium (mEq/L)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
44. Serum creatinine (mg/dL)	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
45. BUN (mg/dL)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	

Worst = highest value with exception of hemoglobin, hematocrit, and sodium. For these items worst is the lowest value (^L)

SECTION VIII: INTERVENTIONS

	<u>Yes</u>	<u>No/Unknown/NR</u>
46. Cardiac (electrophysiologic) ablation therapy	<input type="checkbox"/>	<input type="checkbox"/>
47. Implantable cardiac defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
48. Cardioversion	<input type="checkbox"/>	<input type="checkbox"/>
49. Pacemaker placement (non-biventricular)	<input type="checkbox"/>	<input type="checkbox"/>
50. Biventricular pacemaker (CRT)	<input type="checkbox"/>	<input type="checkbox"/>
51. Coronary Artery Bypass Graft	<input type="checkbox"/>	<input type="checkbox"/>
52. Percutaneous Coronary Intervention (PCI)/stent	<input type="checkbox"/>	<input type="checkbox"/>
53. Valve replacement/repair	<input type="checkbox"/>	<input type="checkbox"/>
54. Intra Aortic Balloon Pump (IABP)	<input type="checkbox"/>	<input type="checkbox"/>
55. Hemofiltration/dialysis	<input type="checkbox"/>	<input type="checkbox"/>
56. Listed/received transplant of heart	<input type="checkbox"/>	<input type="checkbox"/>
57. Left ventricular assist device	<input type="checkbox"/>	<input type="checkbox"/>
58. Was patient counseled regarding the following?		
a. Sodium/cholesterol reduction	<input type="checkbox"/>	<input type="checkbox"/>
b. Tobacco cessation <input type="checkbox"/> N/A	<input type="checkbox"/>	<input type="checkbox"/>
c. Fluid restriction	<input type="checkbox"/>	<input type="checkbox"/>

SECTION IX: MEDICATIONS

	Prior to hospitalization or progression in hospital		At hospital discharge	
	<u>Yes</u>	<u>No/NR</u>	<u>Yes</u>	<u>No/NR</u>
59. ACE inhibitors	<input type="checkbox"/>	<input type="checkbox"/>	a. <input type="checkbox"/>	<input type="checkbox"/>
60. Angiotensin II receptor blockers	<input type="checkbox"/>	<input type="checkbox"/>	a. <input type="checkbox"/>	<input type="checkbox"/>
61. Antiarrhythmics				
a. Amiodarone	<input type="checkbox"/>	<input type="checkbox"/>	a. 1. <input type="checkbox"/>	<input type="checkbox"/>
b. Other	<input type="checkbox"/>	<input type="checkbox"/>	b. 1. <input type="checkbox"/>	<input type="checkbox"/>
62. Anticoagulants	<input type="checkbox"/>	<input type="checkbox"/>	a. <input type="checkbox"/>	<input type="checkbox"/>
63. Anti-inflammatory	<input type="checkbox"/>	<input type="checkbox"/>	a. <input type="checkbox"/>	<input type="checkbox"/>
64. Antiplatelets				
a. Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	a.1. <input type="checkbox"/>	<input type="checkbox"/>
b. Other	<input type="checkbox"/>	<input type="checkbox"/>	b.1. <input type="checkbox"/>	<input type="checkbox"/>
65. Beta blockers	<input type="checkbox"/>	<input type="checkbox"/>	a. <input type="checkbox"/>	<input type="checkbox"/>
66. Calcium channel blockers	<input type="checkbox"/>	<input type="checkbox"/>	a. <input type="checkbox"/>	<input type="checkbox"/>
67. Digitalis ⁶	<input type="checkbox"/>	<input type="checkbox"/>	a. <input type="checkbox"/>	<input type="checkbox"/>
68. Diuretics ⁶	<input type="checkbox"/>	<input type="checkbox"/>	a. <input type="checkbox"/>	<input type="checkbox"/>
69. Aldosterone Blocker	<input type="checkbox"/>	<input type="checkbox"/>	a. <input type="checkbox"/>	<input type="checkbox"/>
70. Lipid lowering agents				
a. Statins	<input type="checkbox"/>	<input type="checkbox"/>	a.1. <input type="checkbox"/>	<input type="checkbox"/>
b. Other	<input type="checkbox"/>	<input type="checkbox"/>	b.1. <input type="checkbox"/>	<input type="checkbox"/>
71. Nitrates	<input type="checkbox"/>	<input type="checkbox"/>	a. <input type="checkbox"/>	<input type="checkbox"/>
72. Hydralazine	<input type="checkbox"/>	<input type="checkbox"/>	a. <input type="checkbox"/>	<input type="checkbox"/>

SECTION IX: MEDICATIONS (continued)

73. IV drugs during this hospitalization?

- a. IV inotropes: Yes No/NR
- b. IV diuretics: Yes NNR
- c. IV vasodilators: Yes No/NR
- d. IV antiarrhythmics: Yes No/NR

