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Patient I.D. ☐☐☐-☐☐-☐☐☐

Date of Birth:	☐☐/☐☐☐/☐☐☐☐ (d d m m m y y y y)
Sex (check one):	☐ Male ☐ Female
Ethnic Category (check one):	☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino
Racial Category (check one): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White	

Patient I.D. ☐☐☐-☐☐-☐☐☐

Cardiovascular History			
Heart Failure	☐ No	☐ Yes	
Myocardial Infarction	☐ No	☐ Yes	
Family history of coronary artery disease	☐ No	☐ Yes	
Hypertension	☐ No	☐ Yes	
Dyslipidemia	☐ No	☐ Yes	
Atrial Fibrillation	☐ No	☐ Yes	
Ventricular arrhythmia	☐ No	☐ Yes	
Diabetes	☐ No	☐ Yes	
Infectious endocarditis	☐ No	☐ Yes	
Peripheral arterial disease	☐ No	☐ Yes	
Peripheral vascular disease	☐ No	☐ Yes	
Cardiovascular Procedure History			
Coronary artery bypass (CABG)	☐ No	☐ Yes	
PCI (Percutaneous Coronary Intervention)	☐ No	☐ Yes	
ICD	☐ No	☐ Yes	
Permanent Pacemaker	☐ No	☐ Yes	
Cardiac transplant	☐ No	☐ Yes	
Cardiomyoplasty	☐ No	☐ Yes	
Left ventricular reduction surgery/ Aneurysmectomy	☐ No	☐ Yes	
Number of prior sternotomies:	☐☐		
Congenital heart surgery	☐ No	☐ Yes	
Cerebrovascular History			
Cerebrovascular disease	☐ No	☐ Yes	
Stroke	☐ No	☐ Yes	
TIA (< 24 hours)	☐ No	☐ Yes	
Carotid stenosis > 75%	☐ No	☐ Yes	☐ Not tested
Prior carotid surgery	☐ No	☐ Yes	
Other History (as defined as STS definition)			
Thyroid disease	☐ No	☐ Yes	
Intrinsic liver disease	☐ No	☐ Yes	
Renal insufficiency	☐ No	☐ Yes	
Gastrointestinal bleeding	☐ No	☐ Yes	
Malignancy (specify type):_____	☐ No	☐ Yes	
Chronic lung disease	☐ None	☐ Mild ☐ Moderate ☐ Severe	
Tobacco use	☐ No	☐ Yes	
Major Depressive disorder or other psychiatric illness	☐ No	☐ Yes	
Current Medical Condition			
Is the patient on an IABP?	☐ No	☐ Yes	

Patient I.D. ☐☐☐-☐☐-☐☐☐

Date of Randomization	☐☐/☐☐☐/☐☐☐☐ d d m m m y y y y
Randomization Assignment ☐ CABG Alone ☐ CABG with Mitral Valve Repair	

Patient I.D. ☐☐☐-☐☐-☐☐☐ **Surgery Date:** ☐☐/☐☐☐/☐☐☐☐
d d m m m y y y y

OPERATIVE PARAMETERS
CPB time (minutes): ☐☐☐

LAD		
Operation	☐ Not bypassed ☐ Vein graft, specify_____ ☐ Mammary Graft	☐ Radial Artery Graft ☐ Other Graft, specify_____
D1		
Operation	☐ Not bypassed ☐ Vein graft, specify_____ ☐ Mammary Graft	☐ Radial Artery Graft ☐ Other Graft, specify_____
D2		
Operation	☐ Not bypassed ☐ Vein graft, specify_____ ☐ Mammary Graft	☐ Radial Artery Graft ☐ Other Graft, specify_____
Ramus		
Operation	☐ Not bypassed ☐ Vein graft, specify_____ ☐ Mammary Graft	☐ Radial Artery Graft ☐ Other Graft, specify_____
OM1		
Operation	☐ Not bypassed ☐ Vein graft, specify_____ ☐ Mammary Graft	☐ Radial Artery Graft ☐ Other Graft, specify_____
OM2		
Operation	☐ Not bypassed ☐ Vein graft, specify_____ ☐ Mammary Graft	☐ Radial Artery Graft ☐ Other Graft, specify_____
OM3		
Operation	☐ Not bypassed ☐ Vein graft, specify_____ ☐ Mammary Graft	☐ Radial Artery Graft ☐ Other Graft, specify_____
OM4		
Operation	☐ Not bypassed ☐ Vein graft, specify_____ ☐ Mammary Graft	☐ Radial Artery Graft ☐ Other Graft, specify_____
RCA		
Operation	☐ Not bypassed ☐ Vein graft, specify_____ ☐ Mammary Graft	☐ Radial Artery Graft ☐ Other Graft, specify_____

RV Marginal Branch		
Operation	☐ Not bypassed ☐ Vein graft, specify_____ ☐ Mammary Graft	☐ Radial Artery Graft ☐ Other Graft, specify_____
RPDA		
Operation	☐ Not bypassed ☐ Vein graft, specify_____ ☐ Mammary Graft	☐ Radial Artery Graft ☐ Other Graft, specify_____
RCPL1		
Operation	☐ Not bypassed ☐ Vein graft, specify_____ ☐ Mammary Graft	☐ Radial Artery Graft ☐ Other Graft, specify_____
RCPL2		
Operation	☐ Not bypassed ☐ Vein graft, specify_____ ☐ Mammary Graft	☐ Radial Artery Graft ☐ Other Graft, specify_____
RCPL3		
Operation	☐ Not bypassed ☐ Vein graft, specify_____ ☐ Mammary Graft	☐ Radial Artery Graft ☐ Other Graft, specify_____

Mitral Valve

Size: ☐☐☐

Were any additional procedures performed? ☐ No ☐Yes

If yes, specify concurrent surgical procedures performed (check all that apply):

- ☐ Closure of PFO
- ☐ Atrial septal defect repair
- ☐ Left atrial appendage ligation/excision
- ☐ Other (specify):_____

Patient I.D. ☐☐☐-☐☐-☐☐☐

1. Test Date: ☐☐/☐☐☐/☐☐☐☐
   d d m m m y y y y

2. Current NYHA Classification

☐Class I ☐ Class II ☐ Class III ☐Class IV

Patient I.D. ☐☐☐-☐☐-☐☐☐

2. Assessment Date: ☐☐/☐☐☐/☐☐☐☐
d d m m m y y y y

3. **Current CCSC:**

☐Grade I ☐ Grade II ☐ Grade III ☐ Grade IV

Patient I.D. ☐☐☐-☐☐-☐☐☐

For Coordinator Only		
Assessment timepoint :	☐ Baseline ☐ 6 mos post intervention	☐ 12 mos post intervention ☐ 24 mos post intervention

For Echo Core Lab Only		
	Mitral regurgitation	
	EROA (PISA Method)	☐.☐☐ cm^2
	Vena Contracta	☐☐.☐ mm
	Integrative assessment of MR	☐ none ☐ trace ☐ mild ☐ moderate ☐ severe
	Left Ventricle Section	
	$LVID_{ED}$	☐.☐ cm
	$LVID_{ES}$	☐.☐ cm
	ESV_{Index}	☐☐☐.☐ml/ m^2
	Left ventricular ejection fraction	☐ ☐ %
	LV Sphericity (ED)	☐ .☐ ☐

Patient I.D. ☐☐☐-☐☐-☐☐☐

The following questions ask how much your heart failure (heart condition) affected your life during the past month (4 weeks). After each question, circle the 0, 1, 2, 3, 4 or 5 to show how much your life was affected. If a question does not apply to you, circle the 0 after that question.
Remember to think about ONLY THE LAST MONTH.

Did your heart failure prevent you from living as you wanted **during the past month (4 weeks)** by. . .

	No	**Very Little**				**Very Much**
MLHF1. causing swelling in your ankles, legs?	0 ☐	1☐	2☐	3☐	4☐	5☐
MLHF2. making you sit or lie down to rest during the day?	0 ☐	1☐	2☐	3☐	4☐	5☐
MLHF3. making your walking about or climbing stairs difficult?	0 ☐	1☐	2☐	3☐	4☐	5☐
MLHF4. making your working around the house or yard difficult?	0 ☐	1☐	2☐	3☐	4☐	5☐
MLHF5. making your going places away from home difficult?	0 ☐	1☐	2☐	3☐	4☐	5☐
MLHF6. making your sleeping well at night difficult?	0 ☐	1☐	2☐	3☐	4☐	5☐
MLHF7. making your relating to or doing things with your friends or family difficult?	0 ☐	1☐	2☐	3☐	4☐	5☐
MLHF8. making your working to earn a living difficult?	0 ☐	1☐	2☐	3☐	4☐	5☐
MLHF9. making your recreational pastimes, sports, or hobbies difficult?	0 ☐	1☐	2☐	3☐	4☐	5☐
MLHF10. making your sexual activities difficult?	0 ☐	1☐	2☐	3☐	4☐	5☐
MLHF11. making you eat less of the foods you like?	0 ☐	1☐	2☐	3☐	4☐	5☐
MLHF12. making you short of breath?	0 ☐	1☐	2☐	3☐	4☐	5☐
MLHF13. making you tired, fatigued, or low energy?	0 ☐	1☐	2☐	3☐	4☐	5☐
MLHF14. making you stay in a hospital?	0 ☐	1☐	2☐	3☐	4☐	5☐
MLHF15. costing you money for medical care?	0 ☐	1☐	2☐	3☐	4☐	5☐
MLHF16. giving you side effects from treatments?	0 ☐	1☐	2☐	3☐	4☐	5☐

Patient I.D. ☐☐☐-☐☐-☐☐☐

	No	**Very Little**				**Very Much**
MLHF17. making you feel you are a burden to your family or friends?	0 ☐	1☐	2☐	3☐	4☐	5☐
MLHF18. making you feel a loss of self-control in your life?	0 ☐	1☐	2☐	3☐	4☐	5☐
MLHF19. making you worry?	0 ☐	1☐	2☐	3☐	4☐	5☐
MLHF20. making it difficult for you to concentrate or remember things?	0 ☐	1☐	2☐	3☐	4☐	5☐
MLHF21. making you feel depressed?	0 ☐	1☐	2☐	3☐	4☐	5☐

Patient I.D. ☐☐☐-☐☐☐-☐☐

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

For each of the following questions, please mark an ☒ in the one box that best describes your answer.

1. In general, would you say your health is:

Excellent	☐1
Very good	☐2
Good	☐3
Fair	☐4
Poor	☐5

2. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐1	☐2	☐3
b. Climbing several flights of stairs	☐1	☐2	☐3

3. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	Yes	No
a. Accomplished less than you would like	☐1	☐2
b. Were limited in the kind of work or other activities	☐1	☐2

Patient I.D. ☐☐☐-☐☐☐-☐☐

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	Yes	No
a. Accomplished less than you would like	☐1	☐2
b. Did work or other activities less carefully than usual	☐1	☐2

5. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all	☐1
A little bit	☐2
Moderately	☐3
Quite a bit	☐4
Extremely	☐5

6. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks…

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a. Have you felt calm and peaceful?	☐1	☐2	☐3	☐4	☐5	☐6
b. Did you have a lot of energy?	☐1	☐2	☐3	☐4	☐5	☐6
c. Have you felt downhearted and blue?	☐1	☐2	☐3	☐4	☐5	☐6

7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	☐1
Most of the time	☐2
Some of the time	☐3
A little of the time	☐4
None of the time	☐5

Patient I.D. ☐☐☐-☐☐☐-☐☐

Check <u>one</u> box for each of the following six health dimensions.

Mobility

I have no problems in walking about	❑
I have some problems in walking about	❑
I am confined to bed	❑

Self-Care

I have no problems with self-care	❑
I have some problems washing or dressing myself	❑
I am unable to wash or dress myself	❑

Usual Activities (*e.g. work, study, housework, family or leisure activities*)

I have no problems with performing my usual activities	❑
I have some problems with performing my usual activities	❑
I am unable to perform my usual activities	❑

Pain/Discomfort

I have no pain or discomfort	❑
I have moderate pain or discomfort	❑
I have extreme pain or discomfort	❑

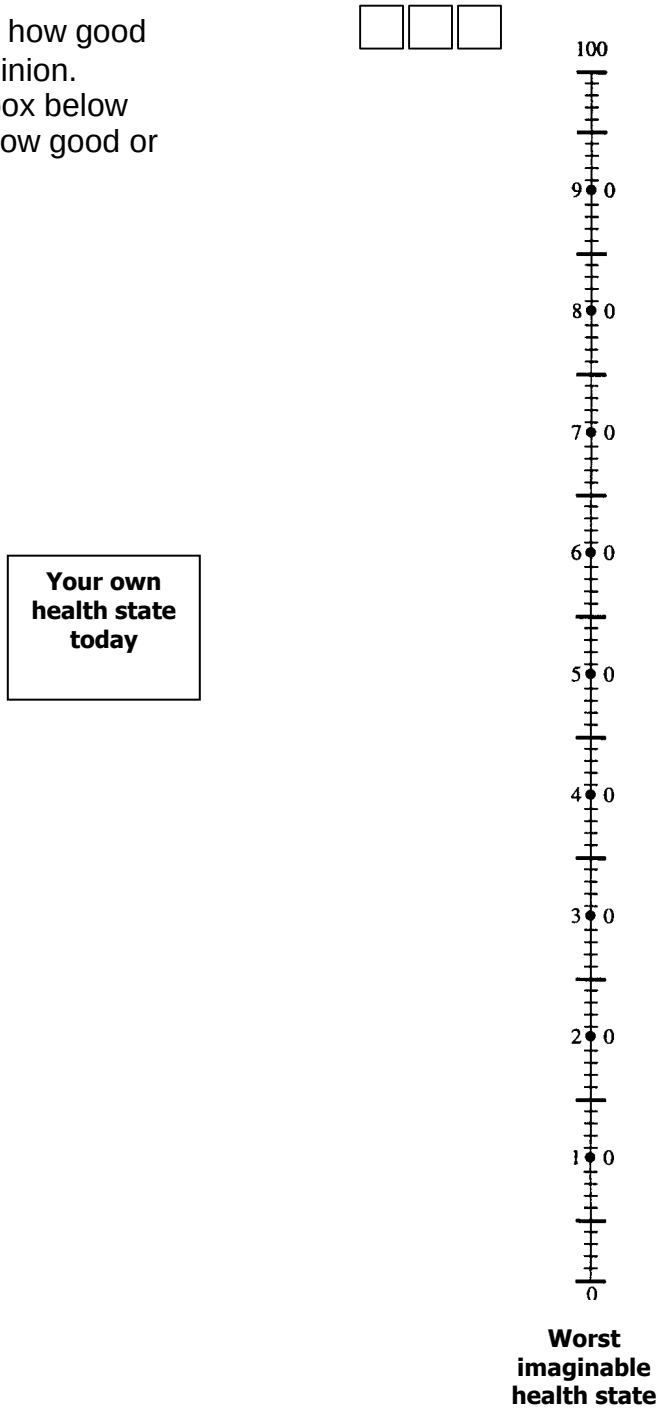
Anxiety/Depression

I am not anxious or depressed	❑
I am moderately anxious or depressed	❑
I am extremely anxious or depressed	❑

Patient I.D. ☐☐☐-☐☐☐-☐☐

To help people say how good or bad a health state is we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked by 100 and the worst state you can imagine is marked by 0.

We would like you to indicate on this scale how good or bad is your own health today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your current health state is.



Patient I.D. ☐☐☐-☐☐-☐☐☐

Could you…	**Yes with no <u>difficulty</u>**	**Yes, but with some <u>difficulty</u>**	**No I couldn't <u>do this</u>**	**Don't do it for other <u>reasons</u>**
1. take care of yourself, that is, eating, dressing, bathing,and using the toilet?	☐	☐	☐	☐
2. walk indoors, such as around your house?	☐	☐	☐	☐
3. walk a block or two on level ground?	☐	☐	☐	☐
4. climb a flight of stairs or walk up a hill?	☐	☐	☐	☐
5. run a short distance?	☐	☐	☐	☐
6. do light work around the house like dusting or washing dishes?	☐	☐	☐	☐
7. do moderate work around the house like vacuuming, sweeping floors, or carrying in groceries?	☐	☐	☐	☐
8. do heavy work around the house like scrubbing floors or lifting or moving heavy furniture?	☐	☐	☐	☐
9. do yard work like raking leaves, weeding, or pushing a power mower?	☐	☐	☐	☐
10. have sexual relations?	☐	☐	☐	☐
11. participate in moderate recreational activities like golf, bowling, dancing, doubles tennis, or throwing a baseball or football?	☐	☐	☐	☐
12. participate in strenuous sports like swimming, singles tennis, football, basketball, or skiing?	☐	☐	☐	☐

Patient I.D. ☐☐☐-☐☐-☐☐☐☐ Adverse Event I.D.:☐☐☐

RECORD THE FOLLOWING DATA FOR EACH ADVERSE EVENT:

Type of adverse event you are reporting (check one event per form submission):

☐ A. Bleeding
☐ B. Cardiac Arrhythmias (specify):
☐ C. Pericardial Fluid Collection
☐ D. Pleural Effusion
☐ E. Pneumothorax
☐ F. Hepatic Dysfunction
Were two hepatic laboratory values greater than three times the upper limit of normal for the hospital?
☐ yes ☐ no
☐ G. Major Infection (specify)
☐ 1. Localized Infection
☐ 2. Endocarditis
☐ 3 Sepsis
☐ H. Myocardial Infarction (specify)
☐ 1. Myocardial Infarction
Check all applicable criteria (at least one criteria needs to be present to be classified as a myocardial infarction)
☐ 2. Peri-CABG Myocardial Infarction
☐ 3. Peri-Percutaneous Intervention (PCI) Myocardial Infarction

I. Neurological Dysfunction
☐ 1. Transient Ischemic Attack -TIA
☐ 2. Cerebrovascular Accident/CVA (specify):
☐ a. Ischemic
☐ b. Hemorrhagic
☐ 3. Toxic Metabolic Encephalopathy
☐ 4. Other Neurological Dysfunction (specify):_____
☐ J. Renal Events (specify)
☐ 1. Renal Dysfunction
☐ 2. Renal Failure
☐ K. Respiratory Failure
☐ L. Heart Failure
☐ M. Arterial Non-CNS Thromboembolism
☐ N. Venous Thromboembolism Event
☐ O. Wound Dehiscence
☐ Z. Other. Specify:_____

Date of onset:
☐☐/☐☐☐/☐☐☐☐
d d m m m y y y y

. Seriousness of Adverse Event:
☐ Serious. Notify DCC immediately
☐ Not Serious

Patient I.D. ☐☐☐-☐☐-☐☐☐☐

Date of Hospital Admission: ☐☐/☐☐☐/☐☐☐☐ (d d m m m y y y y)

Date of Hospital Discharge: ☐☐/☐☐☐/☐☐☐☐ (d d m m m y y y y)

Reason for admission:

- ☐ Index hospitalization
- ☐ Re-hospitalization (specify primary reason):
  - ☐ Cardiovascular
    - ☐ Heart failure (specify applicable signs and symptoms- must be at least two)
      - ☐ Dyspnea felt related to HF
      - ☐ Treatment with intravenous diuretic, vasodilator or intoropic therapy
      - ☐ X ray evidence of pulmonary edema or pulmonary vascular congestion
      - ☐ Rales on physical exam
      - ☐ PCWP or LVEDP > 18 mmHg
    - ☐ Valve Dysfunction (specify): ☐ AV ☐ MV ☐ TV
    - ☐ Other cardiovascular (specify):_____
  - ☐ Non cardiovascular (specify):_____

. Disposition at hospital discharge:

- ☐ Home
- ☐ Skilled nursing care facility
- ☐ Inpatient rehabilitation facility
- ☐ Hospice
- ☐ Death (Complete Mortality form)
- ☐ Other (specify):_____

Patient I.D. ☐☐☐-☐☐-☐☐☐ **Surgery Date:** ☐☐/☐☐☐/☐☐☐☐
d d m m m y y y y

Specify primary procedure performed

☐ Valve repair ☐ MV ☐ TV

☐ Valve replacement ☐ MV ☐ TV

Patient I.D. ☐☐☐-☐☐-☐☐☐ **Date of Death:** ☐☐/☐☐☐/☐☐☐☐
d d m m m y y y y

Patient I.D. ☐☐☐-☐☐-☐☐☐

1. Date of Study completion/Early termination: ☐☐/☐☐☐/☐☐☐☐
   d d m m m y y y y

2. Check primary reason for completion or early termination (check one):

☐ Study completion

☐ Death. Complete mortality form.

☐ Investigator decision to withdraw patient.
Explain:_____

☐ Patient withdrawal of consent.
Explain:_____

☐ Lost to follow-up.
Explain:_____

☐ Other.
Explain:_____