

PATIENT NAME: _____

Date: _____

DOB: _____

INTERVAL HISTORY SINCE LAST VISIT:

General health: good concerns

Comments:

Hospitalizations/ED visits: none yes

Comments:

Medication/supplement changes: No Yes

Comments:

Neuromuscular Function (please circle the best answer):

Overall course for past 6-12 months: Improving stable worsening unsure

Falls: none occasional frequent

Rise from the floor: Normal hands push from floor

hands push from floor and lower extremities needs furniture/unable

Walking: On own needs support assistance

Walking distances: community household only

Walking gait: unable Normal abnormal

Running gait: unable Normal abnormal

Climbing steps: unable normal alternating feet stepping

Jumping: unable Normal abnormal

Hopping on 1 foot: unable Normal abnormal

Muscle cramps: none yes

Comments:

History of discolored dark urine (rhabdomyolysis): No Yes

Comments:

Home stretching program: No Yes, Frequency: _____

Orthotics/braces:

Ankle: No Yes, Frequency: _____

Knee immobilizers: No Yes, Frequency of use: _____

Hand (WHO): No Yes, Frequency: _____

Mobility equipment (please select all that apply):

- None Stroller manual wheelchair
- motorized scooter Power assist wheelchair Power wheelchair (joystick drive)

Fine motor and upper extremity function: No concerns _____

Local neuromuscular provider: no yes _____

Steroid therapy: no yes If yes: Emflaza (deflazacort) or Prednisone

Nutrition:

Calcium from diet – how many servings of each per day? _____ Cups of milk; _____ cheese; _____ yogurt
_____ others

Calcium supplements: No yes If yes, dose? _____

Fruits and veggies: None some a lot

Vit D supplements: None yes, if yes, dose? _____

Bone health:

History of fractures: None Yes

Comments:

New fracture since previous visit: None yes

Comments:

Osteoporosis medications: None Yes (If, yes please make sure you list on Medication list)

Back pain: no yes , Location: _____

Pulmonary health:

Use of one-way valve: no yes

Cough Assist Machine: no yes, If yes, for hyperinflation only with illness both?

BiPAP use: no yes If yes, using nightly? no yes

Ventilator: None sip vent tracheostomy

Sleep: no concerns concerns

Comments:

Endocrine health: no concerns concerns → height growth weight growth puberty

Puberty changes greater than 14 years old: no yes _____(if yes, from what age _____)

Comments:

Cardiac health: no concerns concerns

Cardiac meds: no yes

Comments:

GI/GU heath:

Constipation no yes Frequency of bowel movements: every ____ day(s)

Swallowing difficulties: no yes, if yes explain _____

Urinary problems: no yes, if yes explain _____

History of renal stones: no yes, if yes explain _____

Eye:

no concerns concerns

Comments:

Cataracts: no yes If yes, surgery? no yes

Date of last eye exam due to steroid treatment _____

Mental health:

No concerns

Mood swings anxiety depression

Behavior: no concerns emotional dysregulation anger outbursts

obsessive compulsive tendencies social difficulties with peers

School/learning/work:

_____ grade: Elementary Highschool | Secondary Education/college employed

No concerns learning difficulties attention difficulties

504 plan/IEP : no yes

Comments:

occupation _____

Orthopedics:

No concerns concerns → spine _____ contractures _____

Dental health:

No concerns concerns → _____

Regular dental checks: no yes

Social history: no concerns concerns _____

Change in living/family situation since previous visit? No yes

Comments:

Self Management (for age >10 years):

Diet: No sometimes nearly always

Stretching: No sometimes nearly always

Any additional Comments you would like the clinical team to know not covered above.