THE DUCHENNE PROGRAM

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 choose the best answer):

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

Age at which skills are lost:

1. Inability to rise from the floor independently: _____
2. Inability to go up steps: _____
3. Inability to walk independently: _____
4. Inability to rise from the floor with furniture: _____
5. Inability to walk community distance: _____

Ability to stand between transfers: ◯ No ◯ Yes
Sits: ◯ On Own ◯ independent ◯ With assistance/support

Muscle pains/cramps: ◯ none ◯ pain/cramps in _____ lasting _____

Episodes of discolored urine: ◯ No ◯ Yes

Muscle fatigue: ◯No ◯yes, regularly ◯yes, related to activity

Home stretching program: ◯No ◯Yes _____(frequency)

Comments:

Orthotics/braces:

Ankle: ◯No ◯Yes (frequency of use) _____

Knee immobilizers: ◯No ◯Yes (frequency of use) _____

Hand (WHO): ◯No ◯Yes (frequency of use) _____

Mobility equipment (please select all that apply):

☐None ☐Stroller ☐manual wheelchair ☐motorized scooter

☐Power assist wheelchair ☐Power wheelchair (joystick drive)

Other Equipment (please select all that apply):

☐Bath/shower chair ☐adjustable or hospital bed ☐stander

Upper Extremity Function: ◯Normal ◯Abnormal

Upper extremity support device: ◯No ◯Yes, if yes what device:_____

Comments:

Writing difficulty: ◯No ◯Yes

	On Own	Partial Assistance	Full Assistance
Feeding Self :	◯	◯	◯
Drinking :	◯	◯	◯
Dressing :	◯	◯	◯
Toilet needs :	◯	◯	◯
Turning in bed:	◯	◯	◯

Local neuromuscular provider: ◯No ◯Yes, If yes, Name: _____

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: ◯No ◯Yes If yes, dose? _____

Comments:

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.