DUPUYTREN’S EVALUATION QUESTIONNAIRE

All areas should be filled in.

Patient Name: _____________________________________  Date: ________________

Birth Date: ____/____/____  Age: _______  Gender: ☐ Male  ☐ Female

Which is your writing hand?  ☐ Right  ☐ Left  ☐ Ambidextrous

How old were you when you first noticed Dupuytren's?  _______ (Age)

Which digits are affected by Dupuytren's Disease?

Left:  ☐ None  ☐ Thumb  ☐ Index(Pointer)  ☐ Middle(Long)  ☐ Ring  ☐ Little(Pinky)  ☐ Palm

Right:  ☐ None  ☐ Thumb  ☐ Index(Pointer)  ☐ Middle(Long)  ☐ Ring  ☐ Little(Pinky)  ☐ Palm

How much does your Dupuytren's interfere with the use of the hand?

☐ None  ☐ Minimal  ☐ Moderate  ☐ Severe

How long have the fingers which are really bothering you now been as bent as they are now?  _______________

Have the areas affected by Dupuytren’s been:

Painful?  No  ☐ Yes

Itchy?  No  ☐ Yes

Associated with numbness or tingling?  No  ☐ Yes

Other Conditions in affected areas:

Are there prior injuries to the fingers which are bothering you now?  ☐ No  ☐ Yes

Details: ___________________________________________________________________________________

Did your Dupuytren’s condition seem to start after an injury to the hand or wrist?  ☐ No  ☐ Yes

Details: ___________________________________________________________________________________

Have you had prior Dupuytren's treatment for the areas that are bothering you now:  ☐ No  ☐ Yes

(If yes, please check the appropriate boxes below and/or provide further “details” in “Other” section)

☐ Open surgery  ☐ Skin grafting  ☐ Cryotherapy  ☐ Needle Aponeurotomy

☐ Radiation  ☐ Splinting / Therapy  ☐ Steroid Injection  ☐ Collagenase Injection

Other: ___________________________________________________________________________________

Have you had prior Dupuytren’s treatment for any other areas that are not bothering you now:  ☐ No  ☐ Yes

(If yes, please check the appropriate boxes below and/or provide further “details” in “Other” section)

☐ Open surgery  ☐ Skin grafting  ☐ Cryotherapy  ☐ Needle Aponeurotomy

☐ Radiation  ☐ Splinting / Therapy  ☐ Steroid Injection  ☐ Collagenase Injection

Other: ___________________________________________________________________________________
Do you have a **family history** of Dupuytren’s Disease? □ No □ Yes (please specify below)

- Grandfather
- Father
- Uncle
- Brother
- Son
- Male cousin
- Nephew
- Grandmother
- Mother
- Aunt
- Sister
- Daughter
- Female cousin
- Niece

Have you had any of the following conditions? □ No □ Yes (please specify below)

- Knuckle pads
- Heart disease
- Diabetes
- Ledderhose
- Frozen shoulder
- Peyronie’s
- Liver problems
- RSD
- Gout
- Lung disease
- Seizures

Do you **smoke**?  □ Never  □ Quit less than a year ago  □ Quit over a year ago

- Current (even occasional or "closet smoker")
- Exposed to second-hand smoke

Do you **drink** alcoholic beverages? □ Never □ Quit drinking less than a year ago

- Quit drinking over a year ago
- Socially, not every day
- Drink daily

At the time when you noticed progressive contractures (bending) of your fingers, did your activities include…?

- Riding motorcycles
- Yoga
- Golf
- Other: _______________  □ None of these

Do you take any medications or nutritional supplements? □ No □ Yes (please list)

- Glucosamine
- Glucosamine/Chondroitin
- Other: _____________________________________

Do you have any nodules / cords on the soles of your feet? □ Yes □ No □ Not certain

Please list any additional information our Office should be aware of:

_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Source: This is a modified form template of the original “Dupuytren Evaluation” form template provided, as a courtesy, by Charles Eaton, M.D., Jupiter, Florida, 2009