THE HAND & WRIST CENTER
Specialists in diagnoses, rehabilitation and surgery

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 <u>not</u> 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: _____

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Patient Name: _____ Date: _____

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 ***alcohol***? ☐ 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*