

Dupuytren Evaluation

Surname _____ Given Name _____

Date (dd/mm/yy) ___/___/___ ID# _____

Demographics

Age _____ Gender M F Writing Hand R L B Dupuytren Hand R L B

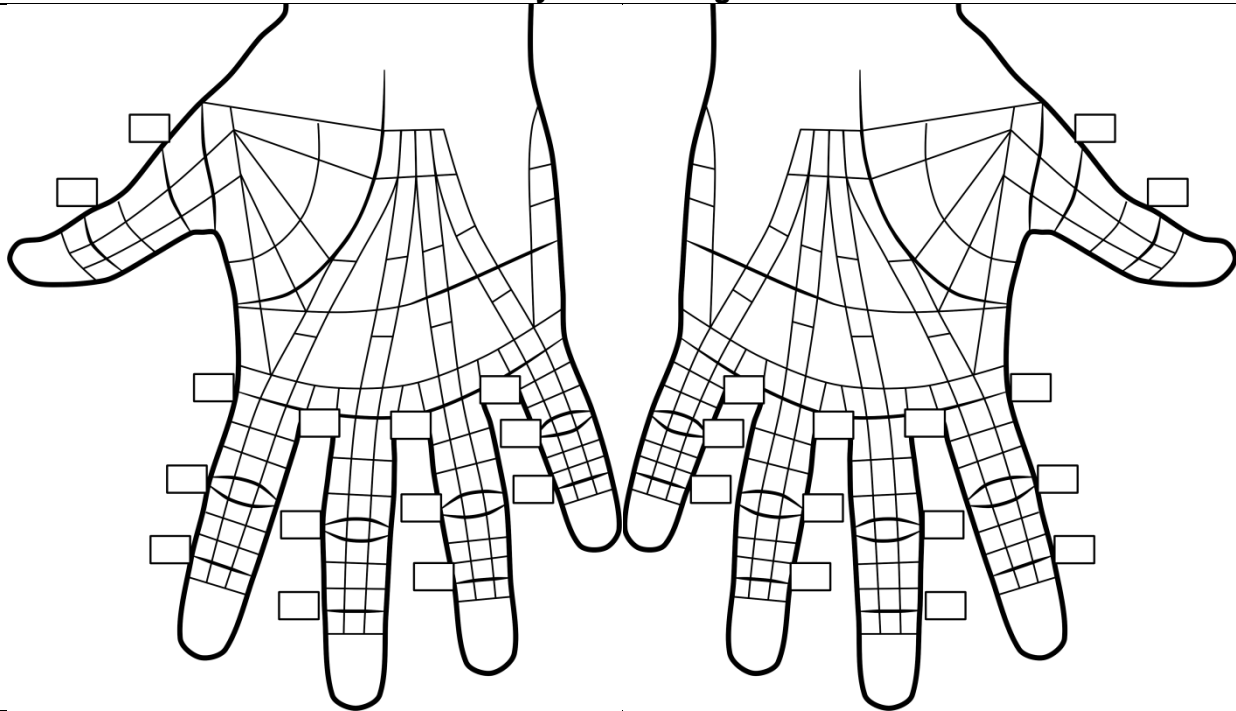
Age at diagnosis _____ Prior treatment Y N (If yes, age at first treatment _____)

History of: Ledderhose Y N Frozen Shoulder Y N Peyronie Y N

Family history of DD Parents Siblings Other None

Family history details: _____

Physical Findings



Mark the diagram using this legend:

Extension Deficit
 Cord
 Nodule
 Skin Involvement
 Skin Graft
 Scar
 Doppler Spiral Bundle

	RIGHT	LEFT
Palmaris Longus	<input type="checkbox"/> Present <input type="checkbox"/> Absent	<input type="checkbox"/> Present <input type="checkbox"/> Absent
Doppler	<input type="checkbox"/> No Exam <input type="checkbox"/> Normal <input type="checkbox"/> Inaudible <input type="checkbox"/> Spiral	<input type="checkbox"/> No Exam <input type="checkbox"/> Normal <input type="checkbox"/> Inaudible <input type="checkbox"/> Spiral
Dorsal Dup Nodule	<input type="checkbox"/> None <input type="checkbox"/> T <input type="checkbox"/> I <input type="checkbox"/> M <input type="checkbox"/> R <input type="checkbox"/> S	<input type="checkbox"/> None <input type="checkbox"/> T <input type="checkbox"/> I <input type="checkbox"/> M <input type="checkbox"/> R <input type="checkbox"/> S
Additional Notes:		

Examiner: _____ Signature: _____