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MHE Orthopaedic Section

MHE Genetic Section

Chronic Pain Section

### Multiple Hereditary Exostoses MHE/ MO / HME

#### CLINICAL INFORMATION FORM

THIS FORM SHOULD BE FILLED OUT BEFORE AND TAKEN WITH YOU TO YOUR PHYSICIANS APPOINTMENT

- Height: \_\_\_\_\_ Weight \_\_\_\_\_ • Age of diagnoses of MHE / MO / HME: \_\_\_\_\_
- Age of first Surgery \_\_\_\_\_ • Age of last surgery \_\_\_\_\_ • Number of surgeries you have had \_\_\_\_\_
- Do you have a family history of MHE / MO / HME ? Yes  or No
- Sites of Exostoses / osteochondroma

Site <a href="#">Hand</a> Yes <input type="checkbox"/> or No <input type="checkbox"/>  Surgery Yes <input type="checkbox"/> or No <input type="checkbox"/>  Number of surgeries _____  Age	Site <a href="#">Elbow</a> Yes <input type="checkbox"/> or No <input type="checkbox"/>  Surgery Yes <input type="checkbox"/> or No <input type="checkbox"/>  Number of surgeries _____  Age	Site <a href="#">Knee</a> Yes <input type="checkbox"/> or No <input type="checkbox"/>  Surgery Yes <input type="checkbox"/> or No <input type="checkbox"/>  Number of surgeries _____  Age
Site <a href="#">Forearm</a> Yes <input type="checkbox"/> or No <input type="checkbox"/>  Surgery Yes <input type="checkbox"/> or No <input type="checkbox"/>  Number of surgeries _____  Age	Site <a href="#">Wrist</a> Yes <input type="checkbox"/> or No <input type="checkbox"/>  Surgery Yes <input type="checkbox"/> or No <input type="checkbox"/>  Number of surgeries _____  Age	Site <a href="#">Ankle</a> Yes <input type="checkbox"/> or No <input type="checkbox"/>  Surgery Yes <input type="checkbox"/> or No <input type="checkbox"/>  Number of surgeries _____  Age
Site <a href="#">Scapula</a> Yes <input type="checkbox"/> or No <input type="checkbox"/>  Surgery Yes <input type="checkbox"/> or No <input type="checkbox"/>  Number of surgeries _____  Age	Site <a href="#">Shoulder</a> Yes <input type="checkbox"/> or No <input type="checkbox"/>  Surgery Yes <input type="checkbox"/> or No <input type="checkbox"/>  Number of surgeries _____  Age	Site <a href="#">Foot</a> Yes <input type="checkbox"/> or No <input type="checkbox"/>  Surgery Yes <input type="checkbox"/> or No <input type="checkbox"/>  Number of surgeries _____  Age
Site <a href="#">Pelvis and Hip</a> Yes <input type="checkbox"/> or No <input type="checkbox"/>  Surgery Yes <input type="checkbox"/> or No <input type="checkbox"/>  Number of surgeries _____  Age	Site <a href="#">Lumbar Spine</a> Yes <input type="checkbox"/> or No <input type="checkbox"/>  Surgery Yes <input type="checkbox"/> or No <input type="checkbox"/>  Number of surgeries _____  Age:	Site <a href="#">Cervical Spine</a> Yes <input type="checkbox"/> or No <input type="checkbox"/>  Surgery Yes <input type="checkbox"/> or No <input type="checkbox"/>  Number of surgeries _____  Age
Site <a href="#">Ribs</a> Yes <input type="checkbox"/> or No <input type="checkbox"/>  Surgery Yes <input type="checkbox"/> or No <input type="checkbox"/>  Number of surgeries _____  Age	Site <a href="#">Fingers</a> Yes <input type="checkbox"/> or No <input type="checkbox"/>  Surgery Yes <input type="checkbox"/> or No <input type="checkbox"/>  Number of surgeries _____  Age	Site <a href="#">Toes</a> Yes <input type="checkbox"/> or No <input type="checkbox"/>  Surgery Yes <input type="checkbox"/> or No <input type="checkbox"/>  Number of surgeries _____  Age

- Have you ever developed a chondrosarcoma? Yes  or No  yes at age: \_\_\_\_\_ location: \_\_\_\_\_

Leg limb-length discrepancies Yes <input type="checkbox"/> or No <input type="checkbox"/>	Bowing in legs? Yes <input type="checkbox"/> or No <input type="checkbox"/>
Leg fixator surgery Yes <input type="checkbox"/> or No <input type="checkbox"/> Age ____	Muscle weakness Yes <input type="checkbox"/> or No <input type="checkbox"/>
Stapling surgery legs Yes <input type="checkbox"/> or No <input type="checkbox"/> Age ____	Chronic fatigue Yes <input type="checkbox"/> or No <input type="checkbox"/>
Shortening of forearm or bowing Yes <input type="checkbox"/> or No <input type="checkbox"/>	Problems sitting Yes <input type="checkbox"/> or No <input type="checkbox"/>
Forearm fixator surgery Yes <input type="checkbox"/> or No <input type="checkbox"/> Age ____	Problems writing Yes <input type="checkbox"/> or No <input type="checkbox"/>
Stapling surgery forearm Yes <input type="checkbox"/> or No <input type="checkbox"/> Age ____	Wound healing problem <u>Keloiding</u> Yes <input type="checkbox"/> or No <input type="checkbox"/>
Has a doctor told you that you have required surgery and you have not had that surgery done?	
Do you have health insurance? Yes <input type="checkbox"/> or No <input type="checkbox"/>	
Do you experience pain? Yes <input type="checkbox"/> or No <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/>	
Do you take over the counter medications for pain? Yes <input type="checkbox"/> or No <input type="checkbox"/>	
Do you take medically prescribed pain medication? Yes <input type="checkbox"/> or No <input type="checkbox"/>	
Have you ever seen a chronic pain specialist? Yes <input type="checkbox"/> or No <input type="checkbox"/>	
What pain medication do you take?	
How long has it been since you have seen a doctor for your MHE?	
How often do you have X-rays taken? _____	
Complications Yes <input type="checkbox"/> or No <input type="checkbox"/> (vessel entrapment, tendon entrapment.....)	
When was the last time you had a body trunk X-ray?	

Does your MHE physically restrict your life in any way?

Do you have trouble walking and or with stairs?

Do you eye problems of any kind?

Do you have stomach or intestinal problems of any kind?

Do you have any heart related defects or heart problems?

Do you have any other medical conditions?

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_ Email: \_\_\_\_\_

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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