Self-Reported History

Form No: **Subject #:** - **Initials:** **Date: (mm-dd-yyyy)** - -

Missing Value Codes: D = Not Applicable X = Unknown

Please tell us about your FSHD history in the following areas:

1. Cardiac History

A. Do you have any history of heart rhythm problems? ☐ Yes ☐ No

If you answered "No" to Question A, please go to Question 2. If you answered "Yes," please continue here:

B. Has it caused you to have:

- ☐ Palpitations
- ☐ Fainting or passing out spells
- ☐ Dizziness or faintness
- ☐ No symptoms but abnormal EKG

C. What type of problems have you had? Please check all that apply.

- ☐ Atrial premature beats
- ☐ Conduction problems or bradycardia (slow rhythm)
- ☐ Supraventricular tachycardia (SVT)
- ☐ Other ____________________
- ☐ I don't know

2. Pulmonary/Breathing Problems

A. Do you have difficulty breathing? ☐ Yes ☐ No

If you answered "No" to Question A, please go to Question 3. If you answered "Yes," please continue here:

B. When do you have problems? Please check all that apply.

- ☐ At rest
- ☐ When lying flat in bed
- ☐ When exercising/upon exertion
- ☐ When sleeping: sleep apnea

C. Does your doctor feel that your breathing problems are related to your FSHD?

☐ Yes ☐ No ☐ I don't know

D. Do you require a breathing machine? ☐ Yes ☐ No

E. If you require a breathing machine, what type of machine do you use? Please check all that apply.

- ☐ BiPAP
- ☐ Ventilator
- ☐ CPAP

PLEASE CONTINUE ON THE NEXT PAGE

Self-Reported History

Form No: ☐☐ **Subject #:** ☐☐ - ☐☐☐ **Initials:** ☐☐☐ **Date: (mm-dd-yyyy)** ☐☐ - ☐☐ - ☐☐☐☐

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3. Vision/Eye Problems

A. Do you have any vision or eye problems (other than needing glasses or contacts)? ☐ Yes ☐ No

If you answered "No" to Question A, please go to Question 4. If you answered "Yes," please continue here:

B. What type of problems have you had? Please check all that apply.

☐ Retinal hemorrhage ☐ Coat's Disease

☐ Retinal detachment ☐ Other (specify) ________________________

4. Hearing Problems

A. Do you have any difficulty hearing? ☐ Yes ☐ No

If you answered "No" to Question A, please go to Question 5. If you answered "Yes," please continue here:

B. If you answered "Yes" to Question A, have you had a hearing evaluation? ☐ Yes ☐ No

C. Do you wear a hearing aid? ☐ Yes ☐ No

5. Ambulation

A. Are you able to walk without any assistive devices (canes, braces, walker)?

☐ Yes

☐ No, I use assistive devices when walking.

☐ No, I am unable to walk at all.

If you answered "Yes" to Question A, please go to Question 6. If you answered "No," please continue here:

B. What assistive devices do you use? Please check all that apply.

1. Ankle braces ☐ ☐ Right ☐ Left ☐ Bilateral
2. Long leg braces ☐ ☐ Right ☐ Left ☐ Bilateral
3. A cane at times ☐
4. A walker at times ☐
5. A wheelchair ** ☐

** If you use a wheelchair, when do you use it?

a. For distances only ☐

b. Usually ☐

c. Always ☐

PLEASE CONTINUE ON THE NEXT PAGE

Self-Reported History

Form No: ☐☐ Subject #: ☐☐ - ☐☐☐ Initials: ☐☐☐ Date: (mm-dd-yyyy) ☐☐ - ☐☐ - ☐☐☐☐

6. Pain Assessment

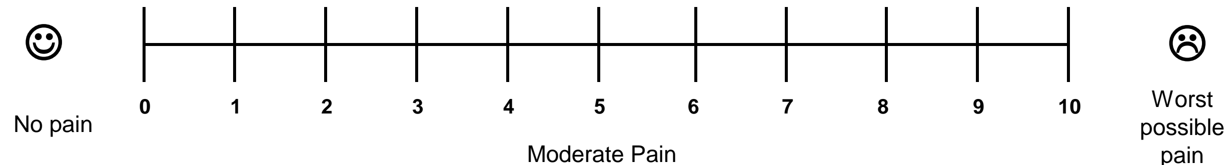
A. Do you have any muscle or joint pain? ☐ Yes ☐ No

If you answered "No" to Question A, please go to question 7. If you answered "Yes," please continue here:

B. If you answered "Yes" to Question A, check all areas affected:

- ☐ neck/upper back
- ☐ lower back/hips
- ☐ shoulders/upper arms
- ☐ knees/thighs
- ☐ elbows
- ☐ ankles/lower legs

C. If you answered "Yes" to Question A, please rate the average intensity of your pain over the last three months by placing a mark on the line below.



D. If you answered "Yes" to Question A, how do you treat your pain? Please check all that apply:

- ☐ Do nothing
- ☐ Massage
- ☐ Medication
- ☐ Hot/cold packs
- ☐ Stretching
- ☐ Other (specify): ____________________

7. Other Signs/Symptoms

A1. Is one arm noticeably more affected by the disease? ☐ Yes ☐ No

A2. If you answered "Yes" to Question A1, which arm is weaker? ☐ Left ☐ Right

B1. Is one leg noticeably more affected by the disease? ☐ Yes ☐ No

B2. If you answered "Yes" to Question B1, which leg is weaker? ☐ Left ☐ Right

C1. Have you had surgery to fix your shoulder blades? ☐ Yes ☐ No

C2. If you answered "Yes" to Question C1, side? ☐ Left ☐ Right ☐ Both

PLEASE CONTINUE ON THE NEXT PAGE

Self-Reported History

Form No:	Subject #:	Initials:	Date: (mm-dd-yyyy)
	-		- -

8. Current Abilities and Restrictions in Movement

To help us understand your current abilities and difficulties, please rate yourself on the following areas:

A. Facial Weakness:

1. Are your eyes occasionally dry and irritated? ☐ Yes ☐ No
2. Are your eyes always dry and irritated? ☐ Yes ☐ No
3. Do you have difficulty pronouncing certain words? ☐ Yes ☐ No
4. Do you have difficulty swallowing? ☐ Yes ☐ No
5. Do you have trouble whistling or drinking through a straw? ☐ Yes ☐ No

B. **Arm function:** Which statement best describes your ability? (Please check only **one** box)

1. You are able to raise your arms up sideways over your head. ☐
2. You are able to raise your arms sideways but not above shoulder level and do not need assistance for activities such as combing or shampooing hair, shaving, applying makeup, brushing teeth, etc. ☐
3. You are able to raise your arms sideways but not above shoulder level and do need assistance for activities such as combing or shampooing hair, shaving, applying makeup, brushing teeth, etc. ☐
4. You are unable to raise arms sideways. ☐

PLEASE CONTINUE ON THE NEXT PAGE

Self-Reported History

Form No: ☐☐ Subject #: ☐☐ - ☐☐☐ Initials: ☐☐☐ Date: (mm-dd-yyyy) ☐☐ - ☐☐ - ☐☐☐☐

8. Current Abilities and Restrictions in Movement (continued)

C. Leg function: Which statements best describe your ability? (Please check **all** that apply)

1. Walk and run ☐
2. Walk but not run ☐
3. Walk and climb stairs without using hand rail or cane ☐
4. Walk and climb stairs only with the help of railing or cane ☐
5. Walk with cane/walker but unable to climb stairs ☐
6. Unable to walk ☐

D. Mobility/Transfers: Which statement best describes your ability? (Please check only **one** box)

1. When getting up from a chair are you able to:
   a. Get up without using your arms (ie; with arms folded across your chest) ☐
   b. Need to use your arms to push up from the chair ☐
   c. Use specific maneuvers to get up from a chair ☐
   d. Get up only with the assistance of a person or device ☐

2. Getting out of bed are you able to:
   a. Sit up from a lying position in bed without any problems ☐
   b. Sit up from a lying position in bed only by using your arms ☐
   c. Sit up from a lying position in bed only by turning sideways and using your arms ☐
   d. Sit up from a lying position in bed only with someone's assistance ☐
   e. Transfer from bed to chair only with assistive devices (ie: walker or bed rails) ☐

PLEASE CONTINUE ON THE NEXT PAGE

Self-Reported History

Form No: | **Subject #:** - | **Initials:** | **Date: (mm-dd-yyyy)** - -

9. Other Medical Problems: Have you ever had or do you have any of these conditions? (check all that apply)

Check all that apply.

- [ ] Diabetes
- [ ] High blood pressure
- [ ] Asthma
- [ ] Rheumatoid arthritis
- [ ] Emphysema
- [ ] Pneumonia
- [ ] Heart Disease or heart beat irregularity
- [ ] Cancer or tumor
  Type ____________
- [ ] High cholesterol
- [ ] Miscarriage
- [ ] Stillbirth
- [ ] Psychological problems such as depression or anxiety
- [ ] Other
  ____
- [ ] Stroke
- [ ] Kidney trouble
- [ ] Thyroid trouble
- [ ] Stomach ulcers
- [ ] Gall bladder trouble
- [ ] Prostate trouble
- [ ] Liver trouble
- [ ] Chronic Infection
- [ ] Trouble with sexual function
- [ ] Acid reflux or "heartburn"
- [ ] Constipation

Thank you!

For Staff Use Only:

____________________________ - -

Signature of Reviewer **Date (mm-dd-yyyy)**