

# DMI HEALTH SUPERVISION CHECKLIST

Reprinted from Neuromuscular Disorders, Health supervision and anticipatory guidance in adult myotonic dystrophy type 1, 20(12), Gagnon, C, Chouinard, M.C., Laberge, L., Veillette, S., Bégin, P., Breton, R., Jean, S., Brisson, D., Gaudet, D., Mathieu, J. Appendix 1. Copyright (2011), with permission from Elsevier.

CONCERNS		INTERVENTIONS
<b>Central nervous system concerns</b>		
Cognitive impairments	<input type="checkbox"/> Normal IQ <input type="checkbox"/> Low IQ <input type="checkbox"/> Intellectual Disability <input type="checkbox"/> Evaluation required	_____
Depression	<input type="checkbox"/> Absent <input type="checkbox"/> Evaluation/treatment required	_____
Excessive daytime sleepiness	<input type="checkbox"/> Absent <input type="checkbox"/> Mild symptoms <input type="checkbox"/> Evaluation/treatment required	_____
Fatigue	<input type="checkbox"/> Absent <input type="checkbox"/> Mild symptoms <input type="checkbox"/> Evaluation/treatment required	_____
<b>Visual concerns</b>		
Ptosis	<input type="checkbox"/> Absent <input type="checkbox"/> Mild, reassess at follow-up <input type="checkbox"/> Moderate <input type="checkbox"/> Evaluation required	_____
Cataracts	<input type="checkbox"/> Absent or aphaky <input type="checkbox"/> Present <input type="checkbox"/> Evaluation required	_____
<b>Respiratory concerns</b>		
Pneumonia	<input type="checkbox"/> Absent <input type="checkbox"/> One or more in the last 6 months	_____
Chronic respiratory failure	<input type="checkbox"/> Absent <input type="checkbox"/> Arterial blood gaz and spirometry required	_____
Sleep disturbances	<input type="checkbox"/> Absent <input type="checkbox"/> Insomnia <input type="checkbox"/> Sleep apnea symptoms <input type="checkbox"/> Oxymetry/PSG required	_____
Vaccination	<input type="checkbox"/> Annual influenza vaccine <input type="checkbox"/> Pneumovax vaccine <input type="checkbox"/> year	_____
Anesthetic risks	<input type="checkbox"/> Information provided	_____
<b>Cardiovascular concerns</b>		
Conduction defects	<input type="checkbox"/> Absent <input type="checkbox"/> Asympto. ECG abnormalities <input type="checkbox"/> Evaluation in cardiology needed	_____
	<input type="checkbox"/> Pacemaker <input type="checkbox"/> year <input type="checkbox"/> Pacemaker/defibrillator <input type="checkbox"/> year	_____
Arterial hypotension	<input type="checkbox"/> Absent <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic AT /	_____
<b>Muscular concerns</b>		
Myotonia	<input type="checkbox"/> Absent <input type="checkbox"/> Mild, no disturbance <input type="checkbox"/> Intervention required	_____
Muscular weakness	MIRS grade	_____
Walking limitations	<input type="checkbox"/> No risk of falls <input type="checkbox"/> Physiotherapist evaluation/equipment required	_____
Transfer difficulties	<input type="checkbox"/> No difficulties <input type="checkbox"/> Occupational therapist evaluation/technical aids required	_____
Wheelchair dependence	<input type="checkbox"/> Not required <input type="checkbox"/> Already provided <input type="checkbox"/> Intervention required	_____
<b>Gastrointestinal concerns</b>		
Dysphagia	<input type="checkbox"/> Absent <input type="checkbox"/> Present but no intervention needed <input type="checkbox"/> Intervention required	_____
Gastroparesis	<input type="checkbox"/> Absent <input type="checkbox"/> Mild/occasional N/V <input type="checkbox"/> Intervention required	_____
Gall-bladder problems	<input type="checkbox"/> Absent/cholecystectomy <input type="checkbox"/> Evaluation required <input type="checkbox"/> Intervention required	_____
Abdominal pain	<input type="checkbox"/> Absent <input type="checkbox"/> Mild/occasional pain <input type="checkbox"/> Intervention required	_____
Constipation/diarrhea	<input type="checkbox"/> Absent <input type="checkbox"/> Mild/occasional constipation or diarrhea <input type="checkbox"/> Intervention required	_____
Anal incontinence	<input type="checkbox"/> Absent <input type="checkbox"/> Mild/occasional incontinence <input type="checkbox"/> Intervention required	_____
Malnutrition	<input type="checkbox"/> Absent <input type="checkbox"/> Mild loss of weight <input type="checkbox"/> Intervention required	_____
<b>Genitourinary and sexual concerns</b>		
Urinary incontinence	<input type="checkbox"/> Absent <input type="checkbox"/> Incontinence ≤ once/month <input type="checkbox"/> Intervention required	_____
Erectil dysfunction	<input type="checkbox"/> Absent/NA <input type="checkbox"/> Presence but no disturbance <input type="checkbox"/> Intervention required	_____
Male infertility	<input type="checkbox"/> Absent/NA <input type="checkbox"/> Intervention required	_____
Gynecologic problems	<input type="checkbox"/> Absent/NA <input type="checkbox"/> Mild menstrual pain/dysmenorrhea <input type="checkbox"/> Intervention required	_____
<b>Metabolic and endocrine concerns</b>		
Obesity	<input type="checkbox"/> Absent <input type="checkbox"/> BMI ≥30 <input type="checkbox"/> BMI >45 <input type="checkbox"/> Weight (kg) <input type="checkbox"/> WC(cm)	_____
Diabetes	<input type="checkbox"/> Absent <input type="checkbox"/> Present <input type="checkbox"/> Last check/year	_____
Hypothyroidism	<input type="checkbox"/> Absent <input type="checkbox"/> Present <input type="checkbox"/> Last check/year	_____
Hypogonadism	<input type="checkbox"/> Absent <input type="checkbox"/> Present <input type="checkbox"/> Last check/year	_____
Dyslipidemia	<input type="checkbox"/> Absent <input type="checkbox"/> Present <input type="checkbox"/> Last check/year	_____
Chronic hepatic dysfunction	<input type="checkbox"/> Absent <input type="checkbox"/> Present	_____
<b>Genetic concerns</b>		
Genetic counselling	<input type="checkbox"/> Information provided <input type="checkbox"/> Family tree completed	_____
Family planning	<input type="checkbox"/> NA <input type="checkbox"/> Appropriate contraception <input type="checkbox"/> Genetic counselling required	_____
Risk for family members	<input type="checkbox"/> NA <input type="checkbox"/> Genetic counselling required	_____
<b>Other health concerns</b>		
Inappropriate use of medication	<input type="checkbox"/> Absent <input type="checkbox"/> Doubt <input type="checkbox"/> Supervision needed	_____
Drug abuse	<input type="checkbox"/> Absent <input type="checkbox"/> Occasional user <input type="checkbox"/> Drug abuse interfering with ADL	_____
Smoking	<input type="checkbox"/> No smoking <input type="checkbox"/> ≤ 40 packs/years <input type="checkbox"/> > 40 packs year	_____
Personal care deficiency	<input type="checkbox"/> No difficulty <input type="checkbox"/> With difficulty but no assistance <input type="checkbox"/> Evaluation required	_____
Pain	<input type="checkbox"/> Absent <input type="checkbox"/> Investigation and treatment required	_____
End of life issues	<input type="checkbox"/> Not appropriate <input type="checkbox"/> Discussion done on advance directives	_____
Information needs	<input type="checkbox"/> Information provided about the disease, researchs and support groups	_____
<b>Social concerns</b>		
Education	Education grade	_____
Employment	<input type="checkbox"/> Never worked <input type="checkbox"/> Currently working <input type="checkbox"/> Used to work/assistance required	_____
Income and financial assistance	<input type="checkbox"/> No problem <input type="checkbox"/> Assistance needed	_____
Home maintenance	<input type="checkbox"/> No difficulty /NA <input type="checkbox"/> Badly kept but acceptable <input type="checkbox"/> Intervention required	_____
Familial and social network	<input type="checkbox"/> Normal social environment <input type="checkbox"/> Unsatisfied by social life <input type="checkbox"/> Social deprivation	_____
Parental care deficiency	<input type="checkbox"/> Absent/NA <input type="checkbox"/> Doubt <input type="checkbox"/> Evaluation required	_____
Car driving	<input type="checkbox"/> NA <input type="checkbox"/> No difficulties <input type="checkbox"/> Evaluation required	_____
Leisure activities	<input type="checkbox"/> Normal hobbies <input type="checkbox"/> Unsatisfied <input type="checkbox"/> Appropriate services required	_____