HYPERMOBILITY EVALUATION WITH DR. PAULUS

The main purpose of your upcoming office visit with Dr. Paulus is to determine whether you do or do not have a genetic connective tissue disorder such as **Hypermobile Ehlers Danlos Syndrome** or **Generalized Hypermobility Spectrum Disorder**.

The diagnosis of hypermobility disorders is made based upon the history provided by you plus a detailed physical examination. **PLEASE COMPLETE THIS ATTACHED "CONNECTIVE TISSUE DISORDER QUESTIONNAIRE"** prior to your office visit with Dr. Paulus.

The initial office visit is for one hour and involves Dr. Paulus taking in a history, performing a targeted physical examination, and then discussing the findings.

A significant part of the exam involves a **detailed inspection of the skin** to determine if you have **stretch marks** (or striae) on your back, buttock area, outer thighs, and upper arms. Dr. Paulus will also need to examine all **scars** from lacerations or past surgeries. Finally, a close exam of the **feet** is required.

What to wear to the first office visit:

1. Loose clothing is preferred.
2. Consider wearing layers that can be removed.
3. Wear a tank top under an upper layer.
4. Consider wearing shorts (in warm weather) or shorts with outer pants that can be removed (in colder weather).
5. Please do not wear leggings.

If you have any questions prior to your hypermobility evaluation, please call the office to discuss with Dr. Paulus.

Thank you . . .

Name: _____

Date: _____

Connective Tissue Disorder Patient Questionnaire

AUTONOMIC NERVOUS SYSTEM:

1. Do you get lightheaded easily, especially when transferring from lying to standing suddenly? ❑ Yes ❑ No
2. Have you ever fainted? ❑ Yes ❑ No
3. Do you have frequent near-fainting episodes due to dizziness? ❑ Yes ❑ No
4. Do you get dehydrated easily? ❑ Yes ❑ No
5. Are you heat sensitive? ❑ Yes ❑ No
   If yes, please give more details:
6. Do you dislike or are intolerant of long hot baths, hot tubs, or saunas? ❑ Yes ❑ No
7. Do you sweat heavily, especially when hot? ❑ Yes ❑ No
8. Do you sweat too little, and then feel too hot? ❑ Yes ❑ No
9. Do you startle easily? Are you easily frightened or jumpy? ❑ Yes ❑ No
10. Have you ever been diagnosed with orthostatic hypotension? ❑ Yes ❑ No
11. Have you ever been diagnosed with Postural Orthostatic Tachycardia Syndrome (POTS)? ❑ Yes ❑ No

ENDOCRINE/DIET:

1. Do you have hypoglycemia or have bouts of low blood sugar? ❑ Yes ❑ No
   If yes, what kind of reactions do you get?
2. Are you sensitive to dietary sugars or simple carbohydrates? ❑ Yes ❑ No
3. Are you currently or have you in the past been gluten free? ❑ Yes ❑ No

CARDIAC/CIRCULATION:

1 Do you get severe cold hands or feet? ❑ Yes ❑ No

2 Have you been diagnosed with Raynaud's Syndrome? ❑ Yes ❑ No

3 Do you have heart palpitations or an irregular heart beat? ❑ Yes ❑ No

4 Have you ever had a brain aneurysm or an aneurysm or dissection? ❑ Yes ❑ No

5 Have you ever had surgery for a heart valve problem? ❑ Yes ❑ No

6 Do you have a heart murmur? ❑ Yes ❑ No

7 Were you born with a heart defect? ❑ Yes ❑ No

8 Have you ever had an echocardiogram (heart ultrasound)? ❑ Yes ❑ No
If yes, what was the reason?

LUNGS:

1. Do you have asthma of any kind: intermittent or constant? ❑ Yes ❑ No

2. Have you ever had a collapsed lung or pneumothorax? ❑ Yes ❑ No

MUSCULOSKELETAL:

1. Have you ever had a joint dislocation or subluxation? ❑ Yes ❑ No
If yes, which joints?

2. Have you ever had a tendon rupture or tear ❑ Yes ❑ No

3. Do you have a ganglion cyst in your hands or feet? ❑ Yes ❑ No

4. Have you ever been diagnosed with a "Tarlov's Cyst" in your sacrum? ❑ Yes ❑ No

5. Are you able to do "joint tricks" such as putting your feet or legs behind your head? ❑ Yes ❑ No

6. Are you "double jointed"? ❑ Yes ❑ No

7. Do you get hand pain after writing or writer's cramp? ❑ Yes ❑ No

8. Do you get frequent leg cramps or a muscle Charlie horse? ❑ Yes ❑ No

9. Have you been diagnosed with fibromyalgia? ❑ Yes ❑ No

10. Do your hands fall asleep easily? ❑ Yes ❑ No

11. Do you have scoliosis (curvature of the spine)? ❑ Yes ❑ No

12. Do you have an unusual shape to your breast bone? ❑ Yes ❑ No
Or, have you been diagnosed with pectus excavatum (hollow chest) or pectus carinatum (protruding breast bone)?

13. Do you have migraine headaches? ❑ Yes ❑ No

14. Do you have flat feet? ❑ Yes ❑ No

15. Do you have osteoporosis (low bone density)? ❑ Yes ❑ No

16. Have you ever had a bone density test, or DEXA scan? ❑ Yes ❑ No

17. Have you ever had a stress fracture of your feet, ankles, hands, or arms? ❑ Yes ❑ No

NEUROLOGIC:

1. Are you uncoordinated? ❑ Yes ❑ No

2. Are you clumsy and sometimes fall or trip easily? ❑ Yes ❑ No

3. Do you have balance problems? ❑ Yes ❑ No

PAIN:

4. Do you have chronic musculoskeletal pain? ❑ Yes ❑ No

5. Do you have chronic pain of any category? ❑ Yes ❑ No
If YES, please give more detail:

VISION:

1. Are you nearsighted (myopia) and wear glasses for distance correction? ❑ Yes ❑ No

   What are the numbers on your prescription? It should read as a minus sign followed by a number, e.g. -2.0 or -3.5:

2. Have you ever had a dislocation of the lens of your eye? ❑ Yes ❑ No

3. Have you ever had a retinal detachment? ❑ Yes ❑ No

EAR, NOSE, AND THROAT:

1. Do you have chronic or recurrent nasal congestion? ❑ Yes ❑ No

DENTAL:

2. Have you had a lot of cavities and fillings, or thin enamel? ❑ Yes ❑ No
3. Do your gums bleed easily and always have even as a child? ❑ Yes ❑ No
4. Have you ever had braces (orthodonture) as a child or as an adult? ❑ Yes ❑ No
5. If you had braces (orthodonture), was it for dental crowding? ❑ Yes ❑ No
6. If you had braces, did you have a palate expander? ❑ Yes ❑ No
7. Do you have temporal mandibular joint (TMJ) pain? ❑ Yes ❑ No
8. When you get numbing medicine for a cavity/filling does the Novocain not work well or take a long time to work? ❑ Yes ❑ No

GASTROINTESTINAL:

1. Do you have problems with your stomach or with digestion? ❑ Yes ❑ No
2. Do you think you have Irritable Bowel Syndrome (IBS)? ❑ Yes ❑ No
3. Have you been diagnosed with IBS? ❑ Yes ❑ No
4. Do you get full easily with a small meal? ❑ Yes ❑ No
5. Do you have, or ever had, heartburn, reflux, GERD, gastritis, or ulcers? ❑ Yes ❑ No
6. Do you have chronic constipation or a tendency to constipation? ❑ Yes ❑ No
7. Do you have hemorrhoids? ❑ Yes ❑ No
8. Have you ever had a rectal prolapse? ❑ Yes ❑ No
9. Do you have/had any hernias: abdominal, belly button, inguinal (groin)? ❑ Yes ❑ No

SKIN:

1. Do you bruise easily? ❑ Yes ❑ No
2. Does your skin seem thin and flexible? ❑ Yes ❑ No
3. Does your skin tear easily? ❑ Yes ❑ No

4. Do you have scars that are wide and thin, like cigarette paper? ❑ Yes ❑ No
5. Have you had stitches that tear out of the skin? ❑ Yes ❑ No
6. Do you have stretch marks anywhere in your body? ❑ Yes ❑ No
7. Do you get hives easily? ❑ Yes ❑ No
   If yes, please describe in more detail the situations:
8. Do you have varicose veins? ❑ Yes ❑ No

URINARY TRACT/GENITALS:

1. Do you have any pelvic floor problems? ❑ Yes ❑ No
2. If you are female, have you ever suffered from:
   a. Uterine prolapse? ❑ Yes ❑ No
   b. Bladder prolapse? ❑ Yes ❑ No
   c. Heavy periods with a lot of bleeding? ❑ Yes ❑ No
   d. Recurrent urinary infections? ❑ Yes ❑ No
   e. Pain with intercourse? ❑ Yes ❑ No
   f. Have you tried to get pregnant and been diagnosed with or treated for infertility? ❑ Yes ❑ No
   g. Have you ever had a miscarriage? ❑ Yes ❑ No

PSYCHOLOGY:

1. Do you suffer from depression? ❑ Yes ❑ No
2. Do you suffer from anxiety or have been diagnosed with an anxiety disorder? ❑ Yes ❑ No

ETC.

1. Are you overly sensitive to light? ❑ Yes ❑ No
2. Do you have abnormal sensitivity to sound? ❑ Yes ❑ No

CONSTITUTIONAL:

1. Do you have chronic fatigue? ❑ Yes ❑ No
2. Do you have concentration difficulties or problems with memory? ❑ Yes ❑ No
3. Do you have "brain fog" or intermittent problems with memory? ❑ Yes ❑ No
4. Do you have an abnormal tiredness that persists after rest? ❑ Yes ❑ No
5. Have you been diagnosed with Lyme disease? ❑ Yes ❑ No
6. Have you been diagnosed with Epstein Bar Virus (EBV)? ❑ Yes ❑ No
7. Have you ever had a concussion that has left you with chronic fatigue? ❑ Yes ❑ No
8. Have you been diagnosed with sleep apnea or think you might have it? ❑ Yes ❑ No
9. Do you suffer from insomnia? ❑ Yes ❑ No

PHYSICAL ACTIVITY:

1. When you were younger, were you a dancer? ❑ Yes ❑ No
2. Do you do yoga? ❑ Yes ❑ No
    a. If yes, is it easy for you to attain complex postures? ❑ Yes ❑ No
3. Do you dislike yoga, because you frequently get hurt? ❑ Yes ❑ No
4. When you were younger, did you require a modified PE class? ❑ Yes ❑ No
5. Do you have problems with exercise in any way? ❑ Yes ❑ No
   If yes, please describe in more detail:

6. Do you have any form of exercise intolerance? ❑ Yes ❑ No
   If yes, please describe in more detail:

7. Do you dislike certain sports or exercises because you frequently get hurt? ❑ Yes ❑ No
   If yes, please describe in more detail:

BIRTH AND EARLY CHILDHOOD DEVELOPMENT:

1. Did you have any complications with your birth? ❑ Yes ❑ No
   If yes, please explain:

2. Were you diagnosed with "floppy baby syndrome? ❑ Yes ❑ No
3. As an infant did you have wry neck or torticollis? ❑ Yes ❑ No
4. As an infant did you have severe colic or excessive vomiting? ❑ Yes ❑ No
5. Did you have delayed development as a baby or toddler? ❑ Yes ❑ No
6. As a child were you clumsy and fell a lot? ❑ Yes ❑ No
7. As a child did you have headaches/migraines or abdominal migraines? ❑ Yes ❑ No
8. As a child did you have abdominal migraines or recurrent abdominal pain, stomach aches, nausea, or vomiting? ❑ Yes ❑ No

ADDITIONAL NOTES: