



## CLINICAL CHECKLIST MULTIPLE OSTEOCHONDROMAS (MO) (EXOSTOSES)

**ONE FORM FOR EACH PATIENT REQUIRED.**

**Checklist online available.**

**PATIENT**

**Name:** .....

**Date of birth:** .....

**Sex:** M / F

**Ethnic origin:** .....

**CLINICAL INFORMATION**

- Height: ..... at age: .....
- Age of onset of MO: .....
- Number of osteochondromas at ..... (age) years (please circle):
  - 1) 1
  - 2) 2 to 5
  - 3) 5 to 10
  - 4) 10 to 20
  - 5) >20

- Site of osteochondroma (please tick):

Site	Site	Site	Site
distal femur	distal tibia		foot
proximal femur	proximal tibia		knee
distal humerus	distal fibula		scapula
proximal humerus	proximal fibula		clavicle
pelvis	spine		other:.....

- Did the patient develop a chondrosarcoma?
 

no	at age: .....
yes	location: .....
- Family history:
  - 1) no family history
  - 2) family history (please include pedigree)
- skeletal deformities:
  - 1) no
  - 2) yes (please specify):

Deformity	Functional impairment	
forearm	decreased range of forearm rotation	
forearm with radial head dislocation	decreased range of elbow flexion	
shortening of forearm	decreased range of knee flexion	
genu vaga	other: .....	
other:.....		

- complications (vessel entrapment, tendon entrapment, ...):
  - 1) no
  - 2) yes (please specify):

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- dental abnormalities: .....
- additional comments / observations: .....

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