Arthrogryposis Multiplex Congenita Questionnaire

Australian Paediatric Surveillance Unit

If you have any questions the investigators may be contacted on (02) 391 9202

REPORTING CLINICIAN

1. APSU Dr Code/Name ☐☐☐☐ /……2. Month/Year of Report …..... /……

2. Name:……

3. Address:……

……Postcode: ……..

4. Telephone:……..Fax: ……..

5. Paediatric Subspecialty (if applicable): ……...

PATIENT

6. First 2 letters of surname ☐☐
7. First 2 letters of first name ☐☐
8. Date of Birth ☐☐ /☐☐/☐☐
9. Sex ☐ M ☐ F ☐ Indeterminate
10. Postcode of residence ☐☐☐☐
11. Description of birth defects:
    a) Limb involvement (please tick appropriate box)

	Right	Left	Bilateral	Not involved
Elbow	☐	☐	☐	☐
Wrist	☐	☐	☐	☐
Hand	☐	☐	☐	☐
Hip	☐	☐	☐	☐
Knee	☐	☐	☐	☐
Ankle	☐	☐	☐	☐

Other (please describe) ……

b) Other birth defects (if applicable) ……...

……

c) Other co-existing conditions (eg intellectual disability, developmental delay) ……

……

d) If the above pattern of birth defects is considered to comprise a described syndrome, please state name of syndrome.

……

12. Results of chromosomal analysis (if available) ……

PRENATAL CONDITIONS

13. Were any conditions present prenatally which may have caused the joint contractures (eg. Oligohydramnios, bifid uterus)?

☐ Yes ☐ No ☐ Unknown

If yes, please specify ……..

PARENTAL/FAMILY HISTORY

14. Maternal age at time of infant's birth (years) ……

15. Paternal age at time of infant's birth (years) ……

16. Parental consanguinity

☐ Yes ☐ No ☐ Unknown

If yes, please describe relationship ……..

17. Previous pregnancies known to be associated with arthrogryposis

☐ Yes ☐ No ☐ Unknown

If yes,

a) Miscarriage/s (less than 20 weeks gestation)

☐ Yes ☐ No ☐ Unknown

b) Stillbirth/s (20 weeks or more gestation)

☐ Yes ☐ No ☐ Unknown

c) Termination/s ☐ Yes ☐ No ☐ Unknown

18. Are there siblings with congenital musculoskeletal deformities?

☐ Yes ☐ No ☐ Unknown

If yes,

a) Total number of siblings ……..

b) Number of affected siblings ……

c) Please describe deformities affecting siblings ……..

……

19. Does either parent have a neuromuscular disease (eg. Myasthenia gravis, myotonic dystrophy)?

☐ Yes ☐ No ☐ Unknown

If yes, please specify condition and affected parent ……....

……

Thank you for completing this questionnaire.

Please return it to: Dr Lee Taylor,
Epidemiology Branch
NSW Health Department
Locked Bag 961
NORTH SYDNEY NSW 2059