MADELUNG – BENIGN MULTIPLE SYMMETRIC LIPOMATOSIS

QUESTIONNAIRE

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INTERVIEWER

Date (dd/mm/yyyy): _____

Interviewer Name: _____

☐ (Introduction; Reason for Phone Call; Explanation of Study; Consent)

IDENTIFICATION

Last Name (and Maiden Name)	
First Name	
Address	
Telephone Number	
E-mail Address	
Male/Female	
DOB (dd/mm/yyyy)	
Ethnicity/Background	

Name of Family Doctor	
Contact Information	

If research with your DNA reveals any medical condition relating to you, do you wish for your family doctor to be informed? ☐ Yes ☐ No

GENERAL PHYSICAL

Height (cm)	
Weight (kg)	
Waist Circumference (cm)	
Blood Pressure	

SOCIAL HISTORY

Smoking:

Have you ever smoked? If so, for how long (how many years) and how much did/do you smoke a day?

_____

_____

Alcohol Consumption:

Do you drink alcohol? If so, how much (per week)?

_____

Can you describe your history of alcohol consumption in the past, particularly before/around the time of diagnosis of Madelung Disease/Lipomatosis?

_____
_____

MEDICAL HISTORY

Madelung Lipomatosis:

Do you have excessive weight gain or lumps around your neck, around your jawline/chin, or on the back (or anywhere else, such as your torso, waist, or lower back)?
Description (Size and Location):_____
_____
_____
_____
_____

Is it symmetrical, in that it is the same when comparing the left and right side of your body? If not, please further describe the location of weight gain/lumps in relation to either side of your body.

_____
_____

When did they first
appear?_____

Have they progressively become worse/better, or changed in any way?_____
Description of Changes:_____
_____
_____

Is your skin red (erythematous) over the areas of weight gain/ lumps?

_____
_____

Is there any associated pain?

_____
_____

Have you experienced any stiffness or movement limitation in the area of weight gain/lumps?

_____
_____

Have you experienced any discomfort or difficulty swallowing (dysphagia)?

_____
_____

Any other associated symptoms or complications?

_____
_____
_____
_____

Can you describe your level of disability (if applicable) due to the condition?

_____
_____
_____
_____

CARDIOVASCULAR, METABOLIC AND OTHER POSSIBLE COMPLICATIONS:

Hypertension:

Do you have a history of high blood pressure? If yes, for how long?
Description:_____
_____

Dyslipidemia:

Do you have a history of dyslipidemia, such as high cholesterol, high triglycerides, low HDL-C (high density lipoprotein – cholesterol), or high LDL-C (low density lipoprotein – cholesterol)?
Description:_____
_____
_____
_____

Cardiovascular disease:

Do you have a history of heart disease, such a heart attack, chest pain (angina), stroke or transient ischemic attack (TIA), a balloon angioplasty or bypass surgery? If so, when?
Description:_____
_____
_____
_____

Diabetes:

Have you ever been diagnosed with type 2 diabetes, non-insulin dependent diabetes, or prediabetes? If so, for how long?
Description:_____
_____
_____
_____

Hyperuricemia:

Have you ever been diagnosed with hyperuricemia, gout, or chronic kidney disease? If so, when?
Description:_____
_____
_____

Renal Tubular Acidosis:

Have you ever been diagnosed with renal tubular acidosis, or any other kidney disease? If so, when?
Description:_____
_____
_____

Hepatic disease:

Have you ever been diagnosed with any liver disease, such as fatty liver or cirrhosis? If so, when?
Description:_____
_____
_____

Hypothyroidism:

Have you ever been diagnosed with hypothyroidism? If so, when?
Description:_____
_____
_____

Peripheral Neuropathy:

Have you ever been diagnosed with peripheral neuropathy, or had any symptoms of muscle weakness or numbness/loss of sensation? If so, when?
Description:_____
_____
_____

Do you have any other medical conditions or health problems?
Description:_____
_____
_____
_____
_____
_____

MEDICATIONS:

Please list your current and past medications, along with the dates they were started/stopped.

SURGICAL/INTERVENTIONAL HISTORY:

Have you ever undergone any of the following procedures/interventions? If so, please give further details, including the date, the reason for intervention, the result, and any complications (if applicable).

Liposuction (Lipoplasty)

Dermolipodectomy

Laserderm

Any Other Surgeries

Physiotherapy

Have you ever had any previous genetic testing done?

FAMILY HISTORY

Do any of your family members have Madelung disease or a similar pattern of weight gain around their neck/shoulder area? If so, please specify who, and at what age they developed the condition.

Has anyone in your family had an early death, heart disease (i.e. a heart attack, angina, stroke or transient ischemic attack, balloon angioplasty or bypass surgery), or diabetes.?

Are there any other notable medical conditions that run in your family that you are aware of?

MTTK8344A.G PHENOTYPES

Do you or anyone in your family have any of the following? If yes, please describe.

Epilepsy/Seizures/Fits?

_____
_____
_____

Jerky, spastic movements that you can't control?

_____
_____
_____

Migraines/ Headaches? With vomiting? Difficulty concentrating?

_____
_____
_____

Eye Issues/Vision Loss?

_____
_____
_____

Hearing Loss?

_____
_____
_____

Memory Loss?

_____
_____
_____

Muscle Weakness? (In the hands/feet? Difficulty standing from sitting/squatting position?)

_____
_____
_____

Issues with coordination?

_____
_____
_____

Issues conducting fine movements?

_____
_____
_____

Overly curved arch of feet?

_____
_____
_____