

DIAGNOSTIC FORM FOR HEREDITARY PERIPHERAL NEUROPATHIES

 CMT TYPE I

 CMT TYPE II

OTHER : (precise) _____

I. INDIVIDUAL INFORMATION

Family name: _____ First name: _____ Date of birth: _____	Date of examination: _____ Initial examination: yes <input type="checkbox"/> no <input type="checkbox"/> Examiner: _____ Tél : _____ E-mail : _____	Propositus: yes <input type="checkbox"/> no <input type="checkbox"/> Sex: M <input type="checkbox"/> F <input type="checkbox"/> Age at examination : _____ Geographical origin: _____
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II. DIAGNOSTIC INFORMATION

Distal motor deficit Upper limbs yes <input type="checkbox"/> no <input type="checkbox"/> Lower limb yes <input type="checkbox"/> no <input type="checkbox"/> Recurrent palsies yes <input type="checkbox"/> no <input type="checkbox"/> Distal amyotrophy Upper limbs yes <input type="checkbox"/> no <input type="checkbox"/> Lower limb yes <input type="checkbox"/> no <input type="checkbox"/>	Proximal motor deficit Upper limbs yes <input type="checkbox"/> no <input type="checkbox"/> Lower limb yes <input type="checkbox"/> no <input type="checkbox"/> Proximal amyotrophy Upper limbs yes <input type="checkbox"/> no <input type="checkbox"/> Lower limb yes <input type="checkbox"/> no <input type="checkbox"/>	Sensory loss <u>Superficial (touch, pinprick thermal)</u> Upper limb yes <input type="checkbox"/> no <input type="checkbox"/> Lower limb yes <input type="checkbox"/> no <input type="checkbox"/> <u>Deep (joint position sense and vibration)</u> Upper limb yes <input type="checkbox"/> no <input type="checkbox"/> Lower limb yes <input type="checkbox"/> no <input type="checkbox"/> <u>Romberg sign</u> yes <input type="checkbox"/> no <input type="checkbox"/>
Areflexia Upper limbs yes <input type="checkbox"/> no <input type="checkbox"/> Lower limb yes <input type="checkbox"/> no <input type="checkbox"/> - Both yes <input type="checkbox"/> no <input type="checkbox"/> - Isolated ankle jerk areflexia yes <input type="checkbox"/> no <input type="checkbox"/>	Nerve hypertrophy yes <input type="checkbox"/> no <input type="checkbox"/> Foot deformities Pes cavus yes <input type="checkbox"/> no <input type="checkbox"/> More important deformation yes <input type="checkbox"/> no <input type="checkbox"/>	Scoliosis yes <input type="checkbox"/> no <input type="checkbox"/> Chronic course yes <input type="checkbox"/> no <input type="checkbox"/>

III. COMPLEMENTARY INFORMATION

Inheritance: -Autosomal dominant yes <input type="checkbox"/> no <input type="checkbox"/> -Dominant yes <input type="checkbox"/> no <input type="checkbox"/> -Autosomal recessive yes <input type="checkbox"/> no <input type="checkbox"/> -Consanguinity yes <input type="checkbox"/> no <input type="checkbox"/> -X-linked yes <input type="checkbox"/> no <input type="checkbox"/> -Isolated cases yes <input type="checkbox"/> no <input type="checkbox"/>	Age of walking _____ Age at onset _____ Disease duration _____	Onset Mode : Upper Limbs yes <input type="checkbox"/> no <input type="checkbox"/> Lower Limbs yes <input type="checkbox"/> no <input type="checkbox"/> Systematic examination yes <input type="checkbox"/> no <input type="checkbox"/>
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Associated signs

Tremor yes <input type="checkbox"/> no <input type="checkbox"/> Auditory loss yes <input type="checkbox"/> no <input type="checkbox"/> Hoarse voice yes <input type="checkbox"/> no <input type="checkbox"/> Glaucoma yes <input type="checkbox"/> no <input type="checkbox"/> Cataract yes <input type="checkbox"/> no <input type="checkbox"/>	Pupillary abnormalities yes <input type="checkbox"/> no <input type="checkbox"/> Trophic troubles yes <input type="checkbox"/> no <input type="checkbox"/> Dysautonomia yes <input type="checkbox"/> no <input type="checkbox"/> Optic atrophy yes <input type="checkbox"/> no <input type="checkbox"/> Retinis pigmentosa yes <input type="checkbox"/> no <input type="checkbox"/>	Pyramidal signs yes <input type="checkbox"/> no <input type="checkbox"/> Cognitive impairment yes <input type="checkbox"/> no <input type="checkbox"/> Cerebellar syndrome yes <input type="checkbox"/> no <input type="checkbox"/> Gastro-intestinal symptoms yes <input type="checkbox"/> no <input type="checkbox"/> Other _____
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Lower limbs scale

- 0 = Normal
- 1 = Normal, but few cramps and fatigability
- 2 = Inability to run and jump
- 3 = Walking difficulties but possible unaided

- 4 = Able to walk only with a cane
- 5 = Able to walk only with crutches
- 6 = Able to walk only with a walker
- 7 = Wheelchair bound
- 8 = Bedridden

Upper limbs scale

- 0 = Normal
- 1 = Cramps
- 2 = Writing fatigability
- 3 = Some difficulties for usual hand gestures
- 4 = Difficulties for usual hand gestures requiring occasional help
- 5 = Fully dependent

EMG: enclose the photocopy of the electrophysiological exam ++++

-Motor Nerve Conductice Velocity of median nerve (MNCV): Left :.....m/s Right :.....m/s

-Distal latencies of median nerves: Left :.....m/s Right :.....m/s

-Coupound Motor Action potential (CMAP) of median nerve : Left :.....mV Right :.....mV

-Sensory potential: Lower limbs: normal decreased absent Upper limbs: normal decreased absent