

Myoclonus-Dystonia Intake Form

Patient's label or identity details: Name (Last, First): ID #: Date of birth:	Sex: <input type="checkbox"/> male <input type="checkbox"/> female Status: <input type="checkbox"/> affected <input type="checkbox"/> healthy Dystonia: <input type="checkbox"/> definite <input type="checkbox"/> probable <input type="checkbox"/> possible <input type="checkbox"/> no dystonia
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Distribution at examination (please tick boxes of involved areas on figure)

Myoclonus	Dystonia
<input type="checkbox"/> 13 Speech	<input type="checkbox"/> 13 Speech
<input type="checkbox"/> 1	<input type="checkbox"/> 1
<input type="checkbox"/> 2	<input type="checkbox"/> 2
<input type="checkbox"/> 3	<input type="checkbox"/> 3
<input type="checkbox"/> 4	<input type="checkbox"/> 4
<input type="checkbox"/> 5	<input type="checkbox"/> 5
<input type="checkbox"/> 6	<input type="checkbox"/> 6
<input type="checkbox"/> 7	<input type="checkbox"/> 7
<input type="checkbox"/> 8	<input type="checkbox"/> 8
<input type="checkbox"/> 9	<input type="checkbox"/> 9
<input type="checkbox"/> 10	<input type="checkbox"/> 10
<input type="checkbox"/> 11	<input type="checkbox"/> 11
<input type="checkbox"/> 12	<input type="checkbox"/> 12

Lab Address (for shipping of DNA or blood samples):
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Dystonia Intake Form

Symptoms at onset:

Myoclonus

Dystonia

Site : Age:	Site : Age:
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Distribution at examination:

(choose one box and tick involved areas on figure)

Myoclonus

Dystonia

<input type="checkbox"/> Generalized (= two or more body segments including the lower extremities) <input type="checkbox"/> Hemimyoclonus (= strictly confined to single side of body) <input type="checkbox"/> Multifocal (= two or more non-contiguous body regions) <input type="checkbox"/> Segmental (= two or more contiguous body regions) <input type="checkbox"/> Focal (one involved body part)	<input type="checkbox"/> Generalized (= two or more body segments including the lower extremities) <input type="checkbox"/> Hemidystonia (= strictly confined to single side of body) <input type="checkbox"/> Multifocal (= two or more non-contiguous body regions) <input type="checkbox"/> Segmental (= two or more contiguous body regions) <input type="checkbox"/> Focal (one involved body part)
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Past Medical History Considered by Investigator as Possibly Associated with M-D (may choose more than one):

<input type="checkbox"/> Anoxia/ complicated pregnancy or delivery	<input type="checkbox"/> Trauma- brain
<input type="checkbox"/> CVA (cerebrovascular accident)	<input type="checkbox"/> Trauma – peripheral
<input type="checkbox"/> Infection	<input type="checkbox"/> Neuropathy in area of dystonia (eg. ulnar)
<input type="checkbox"/> Tumor	<input type="checkbox"/> General anesthesia
<input type="checkbox"/> Mitochondrial disorder	<input type="checkbox"/> Neuroleptic/Dopamine-antagonist exposure
<input type="checkbox"/> Heredodegenerative / metabolic disorder (specify)	(specify drug, if possible)

Family history of Movement Disorders (e.g. dystonia, myoclonus, tremor, parkinsonismus, etc.)

<input type="checkbox"/> Positive	<input type="checkbox"/> Possible	<input type="checkbox"/> Negative	<input type="checkbox"/> Unknown
Please attach pedigree here, if family history is positive or possible and specify symptoms of relatives			

Dystonia Intake Form

Alcohol-responsive:	<input type="checkbox"/> yes	_____ %improvement	<input type="checkbox"/> no	<input type="checkbox"/> not tested
Dopa-responsive:	<input type="checkbox"/> yes	_____ %improvement	<input type="checkbox"/> no	<input type="checkbox"/> not tested

Psychiatric symptoms:

<input type="checkbox"/> No psychiatric symptoms	<input type="checkbox"/> Not assessed
<input type="checkbox"/> Obsessive compulsive disorder OCD (please specify symptoms)	<input type="checkbox"/> Anxiety disorder (please specify symptoms)
<input type="checkbox"/> Alcohol abuse <u>without</u> dependence	<input type="checkbox"/> Alcohol abuse with dependence
<input type="checkbox"/> Depression	<input type="checkbox"/> Other (please specify)

Classification of Myoclonus Dystonia:

<input type="checkbox"/> Myoclonus-Dystonia Syndrom	
<input type="checkbox"/> Essential Myoclonus (myoclonus the only feature)	<input type="checkbox"/> Secondary Myoclonus
<input type="checkbox"/> Primary Dystonia plus (other features)	<input type="checkbox"/> Tardive
<input type="checkbox"/> Dopa-responsive dystonia	<input type="checkbox"/> other (specify)
<input type="checkbox"/> Dystonia-Parkinsonism	
<input type="checkbox"/> Paroxysmal dystonia	<input type="checkbox"/> Heredodegenerative (specify, if known)
<input type="checkbox"/> other (specify)	
<input type="checkbox"/> Unable to definitely classify	<input type="checkbox"/> Asymptomatic Relative

Referred by Name (Last, First)	Institution/Hospital	Date	Signature