






ANTI-NMO ANTIBODIES

PATIENT'S IDENTITY		
NAME: _____	Birth date: _____	
First name: _____	Day	Month
Birth name: _____	<input type="radio"/> Male <input type="radio"/> Female	

PHYSICIAN'S IDENTITY		
NAME: _____	Tel. / fax : _____	
First name: _____	E-mail : _____	
Postal address: _____		

SUSPECTED DIAGNOSIS		
<input type="radio"/> Devic's disease	<input type="radio"/> Isolated transverse myelitis	<input type="radio"/> Retrobulbar Optic Neuritis: severe, recurrent or bilateral
<input type="radio"/> "Optico-spinal" MS	<input type="radio"/> Recurrent transverse myelitis	
<input type="radio"/> Other, specify: _____		

PATIENT'S BACKGROUND		
Patient is caucasoid:	<input type="radio"/> Yes	<input type="radio"/> No
Auto-immune disease:	<input type="radio"/> No	<input type="radio"/> Yes
Tumor:	<input type="radio"/> No	<input type="radio"/> Yes
... If no, specify: _____		
... If yes, specify: _____		
... If yes, specify: _____		

NEUROLOGICAL EPISODES						
Relapsing-remitting phase	 A	 B	Progressive phase	 C	 D	 E
Date of episode onset: _____						
Disease onset: _____						
Date of episode onset: _____						
Episode type (according to classification above): _____						

Clinical syndrome					
MYELITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OPTIC NEURITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Unilateral/Bilateral, Right-Left</i>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Episode semiology					
Walking difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower extremity dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper extremity dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensory symptoms (pain, paresthesia...)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder/bowel dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oculomotor impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facial motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facial sensory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo, hypoacusia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech/swallowing impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental deterioration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paroxysmal symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unknown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Episode features					
Recovery <i>Complete / Incomplete / None</i>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>
Corticosteroid <i>Yes / No</i>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>
treatment <i>If yes: i.v. / i.m. / oral</i>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>
Immunoglobulins i.v. <i>No / Yes</i>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>
Plasma exchange <i>No / Yes</i>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>

