

Clinical checklist Cadasil

CEREBRAL AUTOSOMAL DOMINANT ARTERIOPATHY WITH SUBCORTICAL INFARCTS AND LEUKOENCEPHALOPATHY

CENTRUM MEDISCHE GENETICA UZ GENT

1. Patient information

Name: _____

First name(s): _____

Sex: Male Female

Date of Birth: _____

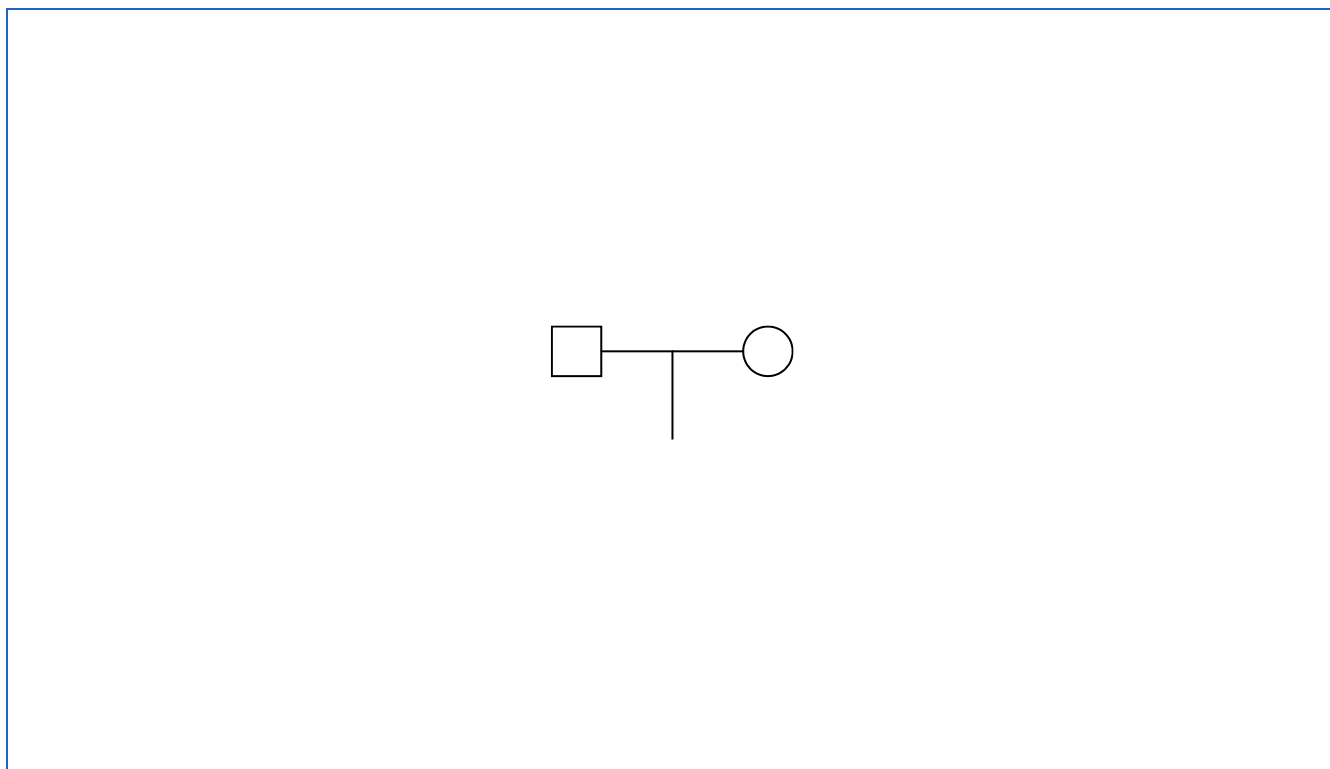
Address: _____

Referring physician: _____

Referring center: _____

Date: _____

2. Pedigree



3. Checklist for CADASIL

Please indicate the clinical characteristics for CADASIL present/absent in your patient.

	present	absent
Migraine without aura	<input type="checkbox"/>	<input type="checkbox"/>
Migraine with aura	<input type="checkbox"/>	<input type="checkbox"/>
TIA or CVA > 50 years	<input type="checkbox"/>	<input type="checkbox"/>
TIA/CVA onset < 50years	<input type="checkbox"/>	<input type="checkbox"/>
Mood and anxiety disturbances	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric disturbances	<input type="checkbox"/>	<input type="checkbox"/>
Alterations in attention and memory	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive decline	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>
Leukoencephalopathy	<input type="checkbox"/>	<input type="checkbox"/>
Leukoencephalopathy extended to temporal pole	<input type="checkbox"/>	<input type="checkbox"/>
Leukoencephalopathy extended to external capsule	<input type="checkbox"/>	<input type="checkbox"/>
Subcortical infarcts	<input type="checkbox"/>	<input type="checkbox"/>
Family history* in at least 1 generation	<input type="checkbox"/>	<input type="checkbox"/>
Family history* in at least 2 generations	<input type="checkbox"/>	<input type="checkbox"/>

*For at least one of the typical features (headache, transient ischemic attack/stroke, cognitive decline, psychiatric disturbances)

4. Other relevant clinical manifestations

- | | |
|---|--|
| <input type="checkbox"/> seizures | <input type="checkbox"/> acute reversible encephalopathy |
| <input type="checkbox"/> intracerebral haemorrhages | <input type="checkbox"/> vertigo (dizziness) |
| <input type="checkbox"/> myocardial infarction | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> visual abnormalities | |