HOPITAL LARIBOISIERE LABORATOIRE D'HISTO-EMBRYO-CYTOGENETIQUE
Prof. E. TOURNIER-LASSERVE

INFORMATION SHEET TO BE COMPLETED WHEN REQUESTING DIAGNOSTIC TESTING FOR FAMILIAL HEMIPLEGIC MIGRAINE

(Enclose a detailed hospital chart)

Patient's first name: Last name:
Maiden name:
Date of birth: Age:

Clinical signs

- Age at first hemiplegic migraine:

Other signs observed **in the patient:**

Inerictal ataxia	yes – no
Interictal nystagmus	yes – no
Epilepsy	yes – no
Convulsions	yes – no
Coma	yes – no
Other	

- Existence of relatives who have had one or more HM attacks: yes – no
(surname of relative if different to patient's name)

- Other signs observed in the patient:

Ataxia	yes – no
Nystagmus	yes – no
Epilepsy	yes – no
Convulsions	yes – no
Coma	yes – no
Migraine with aura	yes – no
Other	

Treatment:

Family tree: