

General Information

Personal details	
Surname:	_____
Forenames:	_____
Date of birth:	_____
Place of birth:	_____
Gender:	_____
Address:	_____ _____
Telephone:	_____
E-Mail:	_____

Referring Physician /Neurologist/ Mental Health Specialist	
Surname:	_____
Forenames:	_____
Hospital:	_____
Address:	_____ _____
Telephone:	_____
E-Mail:	_____

Do you have children?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If YES:			
Surname:	_____	Surname:	_____
Forenames:	_____	Forenames:	_____
Date of birth:	_____	Date of birth:	_____
Gender:	_____	Gender:	_____

Please provide details on further children on a separate sheet if necessary

Did you or your partner have miscarriages or abortions?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, please provide further particulars hereto (e.g. how many miscarriages/ abortions, at which gestational week, reason for abortion [fetal malformation/ disorder?]):		

Please provide details on further miscarriages/ abortions on a separate sheet if necessary

Please provide medical reports/ documents etc., if applicable, via our website www.cegat.com/consultation

Family History / Pedigree

The following question refers to your family over three generations. It comprises your own children – if applicable –, your own brothers and sisters and their children as well as your parents, your parents' siblings and their descendents. The question refers also to deceased relatives

Are there any medical problems or health issues in your family?

(e.g. disabilities, malformations, epilepsy, gait/ neurological/ muscular issues, mental health problems, cardiovascular disorders, cancer, diabetes, hearing or visual impairments)

 Yes

 No

If YES, please provide further particulars hereto (e.g. indicate the affected individual [exact relationship], and which medical problem/ issue occurred at what age; if deceased: at what age and cause of death):

Please provide details on further relatives on a separate sheet if necessary

Do other family members of yours have the same medical problem/ health issue or display similar symptoms ?

 Yes

 No

If YES, please provide further particulars hereto (e.g. exact relationship to affected individual, age at which first symptoms displayed; if deceased: at what age and cause of death):

Please provide details on further relatives on a separate sheet if necessary

Medical History

Which medical problem/ health issue do you display?

Please describe your symptoms and health problems as accurate as possible (e.g. at what age did you experience first symptoms, did they present differently over time [in intensity, severity or peculiarity], which symptoms/ peculiarities did display at what age):

Please provide medical reports/ documents etc., if applicable, via our website www.cegat.com/consultation

Which kind of treatments have been performed to date?

(e.g. surgeries, radiotherapy, physiotherapy, medication, psychotherapy):

Please provide medical reports/ documents etc., if applicable, via our website www.cegat.com/consultation

Do you have any other health issues or pre-existing conditions?
 Yes

 No

If YES, please provide further particulars hereto (e.g. malformations, epilepsy, gait/neurological/ muscular issues, mental health issues, cardiovascular disorders, liver/ kidney disorders, cancer, diabetes, thyroid problems, surgeries, clotting disorders, hearing or visual impairments) including treatments/ therapies/ medication/ in-patient stays, if applicable:

Please provide medical reports/ documents etc., if applicable, via our website www.cegat.com/consultation

Do you consume alcohol, illegal substances [drugs] or do you smoke?
 Yes

 No

If YES, please provide further particulars hereto (e.g. which substance, since when and how long for):

Please provide your most recent body measurements

Height: _____ Date measured: _____

Weight: _____ Date weighted: _____

Head circumference: _____ Date measured: _____

