NAME: ΑΜΚΑ (Social Security number):

ADRESS: PHONE NUMBER:

DATE OF BIRTH:

OPRIGIN:

REFERRAL DOCTOR: PHONE NUMBER:

HOSPITAL:

BIOSPIED MUSCLE:

**CLINICAL INFORMATION**

**History**:

**Family history**:



**Neurological examination**

Walking:

Getting up from a squatting position:

Reflexes:

Muscle strength

Head:

Upper limbs (proximal/distal):

Lower limbs (proximal/distal):

Muscle atrophy:

Hypertrophy/pseudohypertrophy:

Fatigability:

Myotonia:

**Neurophysiology**

EMG: Spontaneous activity:

NCSs:

NMJ examination:

**Biochemistry**

CPK:

LDH:

AST:

ALT:

γGT:

Other:

**Imaging**

Muscle MRI:

Brain MRI:

**Other systems**

Cardiac:

Respiratory:

**Drugs**

**Differential diagnosis**