Cerebral Cavernous Malformation (CCM) Disease Elements

Principal Investigator Responsible for Accuracy of Data (Name):_____ **Subject ID Number:_____**

Is this data Longitudinal (Follow-Up) Data? Yes ☐ No ☐

Subject Zip Code (1st 3 digits): _____ Country of Residence _____

Family Member Samples in Repository? Yes ☐ No ☐ Unknown (subject adopted) ☐ If Yes, list subject ID/s: _____

Year of birth: _____ **Gender**: Male ☐ Female ☐

Ethnic Category (as reported by subject)-Check one: Hispanic or Latino ☐ Not Hispanic or Latino ☐

Racial Categories (as reported by subject) Check One:

American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/ Other Pacific Islander ☐

Black/African American ☐ White/Caucasian ☐ More than One Race ☐ Other ☐ Unknown ☐

Additional Racial and Ethnicity Information: Ashkenazi ☐ Other:_____

Diagnosed By: Neurosurgeon ☐ Neurologist ☐ Pediatric Neurologist ☐ Pediatrician ☐ Other ☐
Primary Care Physician ☐ Psychiatrist ☐ Psychologist ☐ Does Not Apply (Population or Family-Based Control) ☐

Data Collected By: Neurosurgeon ☐ Neurologist ☐ Pediatric Neurologist ☐ Primary Care Physician ☐ Pediatrician ☐
Psychiatrist ☐ Psychologist ☐ Research Coordinator ☐ Registered Nurse ☐ Research Coordinator/ RN ☐

	Present	Absent	Unknown	
Family History of CCM:	☐	☐	☐	If present, list family members _____
Known Genetic Syndrome:	☐	☐	☐	Please specify, if applicable:_____
Known Mutation/s in DNA:	☐	☐	☐	Please specify, if applicable:_____

Number of CCM lesions on MRI ☐Single ☐ Multiple

Age at MRI _____

Presentation at symptom onset ☐Seizure ☐ Headache ☐ Clinical stroke ☐ Asymptomatic

Modified Rankin Score ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6

Optional Data:

Smoking history Never ☐ Previous ☐ Current ☐ Years Smoking, if applicable _____

Handedness Left ☐ Right ☐ Ambidextrous ☐