CLINICAL HISTORY FORM

*** When completed, send this form with the sample or fax it to the Lysosomal Diseases Testing Laboratory at 215-955-9554***

Dr. Name____ Date____________

Address ____
for return ____ Dr. Tel #___________________
of results ____ Dr. Fax #___________________

Patient Name____ Patient ID#_________________

Age (DOB)___________ Sex_______ Race _________________ Religion____________________

Major complaint and history:

Birth and development:

Physical exam:

General appearance:

Eyes and ears:

Facial appearance (Hair, gums, skin, etc.):

Abdomen: Visceromegaly: Liver____________Spleen_____________

Neurological:

Seizures _______________ What type____________________ Drugs _____________________

Tone and strength:

Cranial nerves: Reflexes:

Results of previous testing:

Bone marrow ____________________________ CSF protein____________________

EEG __________________ EMG __________________ Nerve conduction ________________

X-rays ___________________ CT _________________ MRI ___________________________

Urine GAGs or oligosaccharides _______________________

Biopsies _______________________

Other tests (amino acids, organic acids, etc.) _______________________