CLINICAL HISTORY FORM

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

Any questions, please call the laboratory at 215-955-1666

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.) _____