

CLINICAL HISTORY FORM

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

If you have 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 _____ Collection date _____

TEST REQUESTED: Lysosomal Enzyme Screen _____ Single test _____

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:

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.) _____