ARUP® LABORATORIES

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A NONPROFIT ENTERPRISE OF THE UNIVERSITY OF UTAH AND ITS DEPARTMENT OF PATHOLOGY

CLINICAL HISTORY FORM

When completed, send this form with the specimen or fax it to the Lysosomal Diseases Testing Laboratory at (215) 955-9554.

For Return of Results

Doctor name: ______________________________ Date: ______________

Street address: ____

City/State/Zip code: ____

Phone: ________________________ Fax: ________________________

Patient Information

Patient name: ______________________________ Patient ID: ______________

Age and Date of Birth: __________ 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.): ______________________