

Dr. Name _____ Date _____

Dr. Address _____

_____ Dr. Tel # _____

Patient Name _____ **Patient ID#** _____

Age (DOB) _____ Sex _____ Race _____ Religion _____

Major complaint and history:

Birth and development:

Physical exam:

General appearance:

Eyes and ears:

Abdomen: Visceromegaly _____ Liver _____ Spleen _____

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

Neurological:

Seizures _____ What type _____ Drugs _____

Tone and strength:

Cranial nerves:

Reflexes:

Routine lab: Bone marrow _____ CSF protein _____

EEG _____ EMG _____ Nerve conduction _____

X-rays _____ CT _____ MRI _____

Special laboratory tests already performed:

Urine GAGs or oligosaccharides _____

Biopsies _____

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