

LAM Clinic Patient Information

Date: _____

Patient Information

Patient Name:	_____	Date of Birth:	_____
Address:	_____	SSN:	_____
	_____	MRN:	_____

Home Phone:	_____	Office Phone:	_____
Mobile Phone:	_____	Email Address:	_____

Physician Information

Primary Name:	_____	Office Phone:	_____
Email Address:	_____	Specialty:	_____
Secondary Name:	_____	Office Phone:	_____
Email Address:	_____	Specialty:	_____
Add'l Name:	_____	Office Phone:	_____
Email Address:	_____	Specialty:	_____

Insurance Information

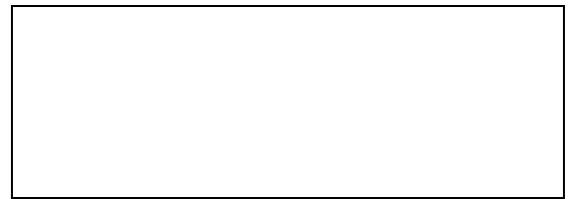
Primary Ins.:	_____	Group No.:	_____
Guarantor:	_____	Policy No.:	_____
Secondary Ins.:	_____	Group No.:	_____
Guarantor:	_____	Policy No.:	_____

Health Information

Date of LAM diagnosis: _____

Medical History: **Pneumothorax, plural effusion, chylous ascites, AMLs, enlarged lymph nodes, other.**
(Please provide a list of dates/types) Please attach additional pages if necessary

Surgical History & Procedures: **Lung biopsy, pleurodesis, fluid removal from lungs, kidney surgery or biopsy, other.**
(Please provide a list of dates/types) Please attach additional pages if necessary



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Hospitalizations: **(Please provide a list of dates/reasons) Please attach additional pages if necessary**

Current Medications: **(Please provide a list of medications, including over-the-counter, vitamins, and herbal).**

Other Medical Problems

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumothorax |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Angiomyolipoma | <input type="checkbox"/> Dyspnea | <input type="checkbox"/> Infections | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> GI problems | <input type="checkbox"/> Neurological Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Obesity | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Ascites | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> |
| <input type="checkbox"/> Chylothorax | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pleural Effusion | <input type="checkbox"/> |

Allergies? _____

- | | | |
|--|------------------------------|-----------------------------|
| Are you pregnant or do you plan to become pregnant? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Are you having problems with anxiety, stress, or depression? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you currently smoke? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| If not, have you ever smoked? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

How were you referred to the Center for LAM Research and Clinical Care? _____

The following specialists are available through Brigham and Women's LAM Center. Please mark the ones you are interested in seeing:

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Nutrition | <input type="checkbox"/> Reproductive Medicine |
| <input type="checkbox"/> GYN/Oncology | <input type="checkbox"/> Obstetrics | <input type="checkbox"/> Thoracic Surgery |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Pulmonary | <input type="checkbox"/> Urology |

Please fax a completed form along with a copy of your current medical records to 617-732-7421:
c/o Betsy Peters BSN, RN
LAM Center Coordinator