BRIGHAM AND WOMEN'S HOSPITAL
A Teaching Affiliate of Harvard Medical School

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

- ☐ Abdominal pain
- ☐ Anemia
- ☐ Angiomylipoma
- ☐ Anxiety
- ☐ Arthritis
- ☐ Ascites
- ☐ Cancer
- ☐ Chylothroax
- ☐ Depression
- ☐ Diabetes
- ☐ Dyspnea
- ☐ GI problems
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Infections
- ☐ Neurological Disease
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pancreatitis
- ☐ Pleural Effusion
- ☐ Pneumothorax
- ☐ Rashes
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Ulcers
- ☐
- ☐

Allergies? _____

Are you pregnant or do you plan to become pregnant?	☐ YES	☐ NO
Are you having problems with anxiety, stress, or depression?	☐ YES	☐ NO
Do you currently smoke?	☐ YES	☐ NO
If not, have you ever smoked?	☐ YES	☐ 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:

- ☐ Dermatology
- ☐ GYN/Oncology
- ☐ Mental Health
- ☐ Nutrition
- ☐ Obstetrics
- ☐ Pulmonary
- ☐ Reproductive Medicine
- ☐ Thoracic Surgery
- ☐ 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