SAVE BLANK DOCUMENT TO YOUR DESKTOP FIRST. YOU MUST COMPLETE, PRINT, AND SCAN AND E-MAIL (attach and e-mail to marfan2010@bcm.edu), FAX, OR SEND VIA U.S. MAIL BACK TO US. OPTIONALLY, YOU CAN PRINT AND FILL IN BY HAND.

Baylor College of Medicine/University of Texas Health Sciences Center Houston
26th Annual National Marfan Foundation Conference Health Fair
(Marfan Syndrome, Related Aortic Disorders and Valve Diseases)

HEALTH FAIR INFORMATION FORM

Are you registered for the 2010 NMF Conference in Houston, TX, July 8-11th? YES ☐ NO ☐
Have you been seen at a previous NMF Conference? Yes ☐ (If YES, when_____?) NO ☐

Demographic Information (One completed form PER PERSON) Today's Date _____

Name _____

Date of Birth _____ Age _____ Gender (Please check one): M F

Street Address _____

City _____ State _____

County _____ Zip code _____

Phone Numbers: HOME _____ CELL _____WORK _____

E-Mail _____

Fax number _____

Emergency Contact _____Relationship _____

Contact Phone _____

Do you have a Primary Medical Doctor? (Check one) YES ☐ NO ☐ If YES, please indicate:

Name of Physician: _____

Street Address 1: _____

Street Address 2: _____

City: _____ STATE ____ ZIP _____ Phone _____

Do you have Health Insurance? YES ☐ NO ☐

Name _____

Have you been formally diagnosed with Marfan Syndrome? YES ☐ NO ☐

When (mm/yy) _____ Where (Institution/Physician) _____/ _____

Age at Diagnosis____ Do you question your diagnosis? YES ☐ NO ☐

Do you have questions/concerns about having a child? YES ☐ NO ☐

Please tell us why you want to participate in the Health Fair portion of the NMF Conference:

_____

_____

_____

Height __'__" Weight _____lbs Shoe Size ____ Smoker? NO ☐ YES ☐ # YEARS ___

Alcohol Consumption? NO ☐ YES ☐ # YEARS ____ # Drinks per day ____

Other Substances: NO ☐ YES ☐ If 'Yes' what kind? _____

Current Medications

Name	*Dosage*	*x per day*	*Have been taking for*
_____	_____	_____	____Years ____Months
_____	_____	_____	____Years ____Months
_____	_____	_____	____Years ____Months
_____	_____	_____	____Years ____Months
_____	_____	_____	____Years ____Months

Any allergies? NO ☐ YES ☐ If 'YES' Please list:

_____ _____

_____ _____

Name _____

Cardiac History (check **all** you have)

___ Mitral Valve Prolapse ___ MV Regurgitation ___ Aortic Stenosis ___ AV Regurgitation

___ Bicuspid Aortic Valve ___ Tricuspid Valve Disease ___ Aneurysm ___ Dissection

___ Irregular Heart Beats ___ Palpitations ___ High Cholesterol ___ Hypertension

___ History of Chest Pain ___ Valve Replaced (If so: ___ Tissue ___Mechanical) ____Valve Spared

Do you have any symptoms? NO ☐ YES ☐ If 'YES' what are your symptoms?

_____

Have you had heart or aortic surgery before? NO ☐ YES ☐ If 'YES' where, when, what type:

_____

_____

Physical Manifestations (check **all** you have)
Long: face ☐ neck ☐ arms ☐ hands ☐ fingers ☐ legs ☐ feet ☐ toes ☐
Roof of mouth high ☐ narrow bite ☐ crowded teeth ☐
Wear braces ☐ multiple tooth extractions ☐ palate spreader ☐
Hypermobile (double) jointed? Fingers ☐ wrist ☐ elbows ☐ shoulders ☐
Hypermobile (double) jointed)? Toes ☐ ankles ☐ knees ☐ hips ☐ dislocations ☐
Spontaneous Pneumothorax (collapsed lung)
Contractures? toes (hammer toes) ☐ contractures of fingers ☐
Stretch marks ☐ Hernias ☐
Migraine headaches ☐

Eye History (check **all** you have)

Last (slit eye) exam? _____

Corrective Lenses ____ Contacts or Glasses ____ Cataracts or Glaucoma____

Near sighted (can't see distance) ____ Far sighted (can't see close) ____

Lens dislocation/ retinal detachment _____ (if yes, please attach a copy of your ophthalmology report)

Name _____

Orthopedic History (**place an 'X' next to any that you have**)

Kyphosis ____ Scoliosis ____ Spondylolithesis (vertibral slipping) ____

Dural Ectasia ____ Harrington Rods ____ Hip Deformity ____ Joint Replacement ____

Other Joint Surgery ___ Other Joint Dislocations ____ Flat feet ____ Foot Pain ____

Pectus Excavatum ___ Pectus Carinatum _____ If yes to either, was repair done? YES ___NO ___

IF YOU HAVE BEEN GIVEN A DIAGNOSIS OF LOEYS-DIETZ SYNDROME, PLEASE COMPLETE THE FOLLOWING: (if not, skip to next page)

Loeys-Dietz Syndrome (**place an 'X' next to any that you have)**

Arterial Tortuosity ____ Aneurysm/Dissection Other Than the Aorta ____

Widely-spaced eyes ____ Wide or Split Uvula ____ Cleft Palate ____

Club foot ____ Atrial-Septal Defect (ASD) ____ Patent Ductus Arteriosis ____

Bicuspid Aortic Valve ___ Easily Bruised ____ Wide Scars _____ Soft Skin _____

Osteoporosis ____ Spinal Malformation ____

Uterine Rupture During Pregnancy ____

Name _____

Please include ages & heights for the following:

Children	**Daughter/Son**	**First Name**	**Age**	**Height**	
	_____	_____	___	___’___”	
	_____	_____	___	___’___”	
	_____	_____	___	___’___”	
	_____	_____	___	___’___”	
Siblings	**Brother/Sister**	**First Name**	**Age**	**Height**	
	_____	_____	___	___’___”	
	_____	_____	___	___’___”	
	_____	_____	___	___’___”	
	_____	_____	___	___’___”	
Half-siblings	**Brother/Sister**	**First Name**	**Age**	**Height**	**Maternal/Paternal**
	_____	_____	___	___’___”	_____
	_____	_____	___	___’___”	_____
	_____	_____	___	___’___”	_____
	_____	_____	___	___’___”	_____
Parents	**Mother/Father**	**First Name**	**Age**	**Height**	**If deceased, cause?**
	_____	_____	___	___’___”	_____
	_____	_____	___	___’___”	_____
Aunt/Uncle	**Aunt/Uncle**	**Name**	**Age**	**Height**	**Maternal/Paternal**
	_____	_____	___	___’___”	_____
	_____	_____	___	___’___”	_____
	_____	_____	___	___’___”	_____

_____ _____ ___ ___’___” _____

Name _____

Grandparents

Gr. Father/Gr. Mother	Name	Age	Height	If deceased, cause?
Paternal GF	_____	___	___’___”	_____
Paternal GM	_____	___	___’___”	_____
Maternal GF	_____	___	___’___”	_____
Maternal GM	_____	___	___’___”	_____

Have any family members been diagnosed with:

1. Marfan Syndrome? Yes ☐ No ☐ Who? _____
2. Aortic Disease? Yes ☐ No ☐ Who? _____
   (Dissections/Aneurysms)
3. Bicuspid Aortic Valve? Yes ☐ No ☐ Who? _____
4. Aortic and/or Heart Valve Surgeries? Yes ☐ No ☐ Who? _____
   (If surgery was done, please send/bring copies of operative reports/pathology reports)
5. Sudden Death? Yes ☐ No ☐ Who? _____
   (If yes, was an autopsy performed? Yes___No___ (please bring copy of the autopsy report).

Other Operations or Hospitalizations

1. _____ 4. _____
2. _____ 5._____
3. _____ 6._____

Checklist of records (if applicable) that you will need to bring along to your appointment

1. Records of dilated slit lamp eye examinations ☐
2. Echocardiogram (CD’s ONLY) with DICOM viewer ON THE CD and the written report ☐
3. CT films☐, MRI films☐ with written reports ☐
4. Recent pertinent laboratory test results ☐
5. Other pertinent medical records☐, physician notes☐, growth charts ☐
6. Family photographs if possible (affected and unaffected family members)
7. Operative reports ☐
8. Autopsy reports (if applicable) ☐

Name _____

All patients must sign a Consent Form before their Health Fair appointment. The reason for the consent is:

- **To ensure your complete understanding that this visit is for informational purposes only. It is not a formal evaluation, which can only be done by your personal physician**
- **The physicians you will see during your visit are not your caregivers**
- **The purpose of this Health Fair, is to educate interested individuals about the risks of Marfan syndrome and related disorders**

IMPORTANT

In order to process your request for testing (echocardiogram or eye exam) we need to have the following items returned to us by scanning and e-mailing, faxing, or to the address below by mail:

1. **This form, as complete as you can make it (Keep a printed copy for yourself. Forms cannot be saved.)**
2. **The PARTICIPANT CONSENT AND RELEASE, fully completed and signed**
3. **The BAYLOR COLLEGE OF MEDICINE ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE fully completed and signed**

Please scan and e-mail forms to marfan2010@bcm.edu or fax to 832-355-9940 or mail to address below.

Please print, read and KEEP FOR YOUR RECORDS the BAYLOR COLLEGE OF MEDICINE PRIVACY NOTICE

Our goal is to have clinic schedules completed by mid-May. We will be in contact with you before that time. Please e-mail us with any questions or needs that we can help you with.

Kathy Loring, RN, ACNP
Baylor College of Medicine
Marfan Conference 2010
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(832) 355-9919