

Application for Membership

Name _____ Date _____

Address _____

City, State, Zip _____

Home Phone _____

Work Phone _____

Fax _____

E-Mail _____

Membership Level

Member \$30 Friend \$50 Sponsor \$100 Donor \$500 Benefactor \$1,000

I would also like to purchase the Special Newsletter for an additional \$20.00 (enclosed)

Are you a: Patient Family Member Doctor Other _____

p
a
t
i
e
n
t
i
n
f
o
↓

Date of Birth _____ Gender (circle one) Male Female

Occupation (current of former) _____

Tumor Location/Source of Cushing's _____

Age at Diagnosis _____

Month/Year Diagnosed _____

How long did you have Cushing's before diagnosis? _____

How many physicians did you see before diagnosis? _____

Who originally suggested Cushing's as your diagnosis? (physician, friend, read about) _____

PRIVACY - If you do not want to answer any of these questions, leave blank. Please indicate if you wish to keep any of this information private to this organization.

Transsphenoidal surgery: yes no When _____ Where _____

Adrenalectomy: Unilateral or Bilateral When _____ Where _____ By Laparoscopy _____

Radiation: Type: _____ Where/When _____

2nd Surgeries (please give details) _____

Other _____

How did you hear about CSRF?

What would you like CSRF to do for you?

Was your family/spouse supportive?

Please send with payment to:
CSRF
65 E India Row, #22B
Boston, MA 02110

.....

Do you have any of the following?

- Diabetes Insipidus
- Diabetes
- Nelson's Syndrome
- Total pituitary removed
- Other - please list

.....

What 5 symptoms of Cushing's do you feel were most evident with you? List most evident to least.

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____

Please attach an additional sheet for:

- any other comments
- any other information about yourself
- your story
- questions for our Medical Advisory Board

How much weight did you gain? _____

.....

If you would like a complimentary newsletter/information packet sent to your doctor(s) please complete the following (all information, including zip code, must be included):

Name _____

Specialty _____

Address _____

City, State, Zip _____

Name _____

Specialty _____

Address _____

City, Sate, Zip _____

Name _____

Specialty _____

Address _____

City, State, Zip _____