A Better Way Counseling Center
818 NW 17th Suite 8
Portland, OR 97209
(503) 226-9061

Medical History - Eating Disorders

Patient Name: ________________________________ Date: ______________________

[ ] Headaches
[ ] Blurred vision or visual changes
[ ] Bloody noses
[ ] Broken blood vessels in face or eyes
[ ] Condition of teeth
[ ] Sore throats
[ ] Swollen glands
[ ] Urinary frequency
[ ] Kidney stones
[ ] Pneumonia due to aspiration
[ ] Dyspnea
[ ] Palpitations
[ ] Other ____________________________
[ ] Chest pain
[ ] Edema
[ ] Cold or heat intolerance
[ ] Constipation
[ ] Diarrhea
[ ] Blood in emesis
[ ] Heartburn
[ ] Abdominal pain
[ ] Amenorrhea
[ ] Irregular periods
[ ] Numbness & tingling in extremities
[ ] Does self breast exam (if applicable)

Menarche age _____
Last P.A.P. date _________ abnormal? _______
Comments: ____
____
____
____
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Please provide us with copies of the lab reports for the following:

CBC platelet ct.	UA
Sed Rate	AM or PM timed cortisol
SMAC-20	free T4
Amylase	TSH

If indicated, please also provide the following:

x-ray	EKG
bone densitometry	

and any other pertinent test.

P H Y S I C A L

age _______ weight _______ height _______

temperature _____ blood pressure ________ pulse _________

orthostatic BP and P: ____

____

medications: ____

general information: ____ ___

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		Normal		Abnormal	Additional comments and explanation of abnormal findings:
Integumentary					
turgor		[_____]		[______]	
dry skin		[_____]		[______]	
lanugo	no-	[_____]	yes-	[______]	________________________________
Head and Neck					________________________________
sinus		[_____]		[______]	________________________________
teeth & enamel		[_____]		[______]	
pharynx		[_____]		[______]	________________________________
adenopathy		[_____]		[______]	
thyroid		[_____]		[______]	________________________________
Chest		[_____]		[______]	________________________________
Heart		[_____]		[______]	________________________________
Abdomen		[_____]		[______]	________________________________
Neuro		[_____]		[______]	________________________________
Gyn		[_____]		[______]	________________________________

Comments and Recommendations: ____

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Next Visit Date (if indicated): ____________________ Recommended Frequency ___________

Physician Signature: ____