A Better Way Counseling Center
818 NW 17th Suite 3
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: _____
_____
_____
_____
_____
_____

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: _____ ___

_____

_____

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

Comments and Recommendations: _____

_____

_____

_____

_____

_____

_____

Next Visit Date (if indicated): _____ Recommended Frequency _____

Physician Signature: _____