Edward P. Tyson, M.D.
3811 Bee Caves Rd., Ste 200, Austin, TX 78746 Ph. (512) 380-9999 Fax: (512) 380-0072
www.EatingDisordersDoc.com

Demographic Sheet

____
Last Name (Patient Information) First Middle Social Security Number

____
Home Address Apt # City State Zip

____(____)__________(____)__________
Date of Birth Age Marital Status Home Phone Cell Phone

_____________________________________ _________________(____)__________
e-mail address Emergency contact name/Relationship Phone

____
Employer name/School attending (circle) Address

____(____)___________
City State Zip Phone

____
Spouse/partner/parent/guardian Last name First name Middle initial

____(____)__________(____)_______
Social Security Number Sex Date of Birth Age Work phone Cell phone

____
Insurance Company Address City State Zip

(____)____
Insurance Phone Number ID Number Group Number

____
Name of insured Relationship Date of birth of insured

____(____)__________
Address of insured City/State/Zip Phone

I hereby authorize Dr. Edward P. Tyson, to furnish information to insurance carriers concerning this illness, as required by the insurance carrier and as defined in the previously provided paperwork outlining Dr. Tyson's office policies and procedures. **As a reminder, payment is due in full at time of service as we do not accept any insurance.**

______________________________ ______________________________________
Signature Date Parent or guardian if patient is a minor Date

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First Visit Information

Your name: ____ Date:____/____/______

Why did you come to see Dr. Tyson today?
____

How did you hear about Dr. Tyson?____
Are you in school? __________ If so, where? ____________________________________
Are you working? ____________ If so, what is your job?____________________________

Any long range plans?

With whom do you live?
_______Both natural parents ________Spouse
_______Mother ________Stepmother
_______Father ________Stepfather
_______Alone ________Roommate
_______Other: Explain:______________________________

Have there been any changes in your immediate family, such as:
________Marriage ________Births ________Deaths
________Divorce ________Loss of job ________Move to new house
________NO CHANGES

What would you like to change about your life?
____

List any and all medications (including 'over-the-counter' meds) that you are taking and the problem for which the medicine is taken:

Medicine:	Reason:
__________________________	____
__________________________	____
__________________________	____

List all allergies to medications:

________________________	____
__________________________	____
__________________________	____

List all hospitalizations, their dates, and for what problems below:

Dates:	Reason:	Problem:
_______________	________________	____
_______________	________________	____
_______________	________________	____

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Medical Questionnaire

Below are listed a number of common problems. Circle YES or NO to each question. This information is STRICTLY CONFIDENTIAL. Hand this sheet directly to the doctor or nurse. This information will not be shown or given to any one else, unless you specifically request to do so.

1. Do you think there is something wrong with your health? YES NO
2. Are you often upset? YES NO
3. Do you have trouble falling asleep or waking up during the night? YES NO
4. Do you think you are overweight or underweight? YES NO
5. Are you doing well in school (if applies)? YES NO
6. Are you having difficulties at home? YES NO
7. Were you adopted? YES NO
8. Have you ever lived in foster care or an institution? YES NO
9. Are you bothered by severe headaches? YES NO
10. Are you bothered by stomachaches or stomach problems? YES NO
11. Are you bothered by dizzy spells? YES NO
12. Do you think you are too short or too tall? YES NO
13. Do you have trouble making friends? YES NO
14. Do you think there is something wrong with your head or brain? YES NO
15. Are you unhappy with your skin (complexion)? YES NO
16. Do you think something is wrong with your ears or hearing? YES NO
17. Do you think something is wrong with your eyes? YES NO
18. Do you think something is wrong with your breathing? YES NO
19. Does it burn or hurt when you go to the bathroom? YES NO
20. Have you had any urinary or kidney infections? YES NO
21. Do you have high blood pressure? YES NO
22. Do you have muscle or joint pain? YES NO
23. Do you have allergies? YES NO
24. Are you worried you might have cancer? YES NO
25. Have you fainted or passed out lately? YES NO
26. Do you have chest pain? YES NO
27. Do you smoke cigarettes? YES NO
28. Do you smoke joints? YES NO
29. Do you drink alcohol? YES NO
30. Do you have any bad habits you would like to get rid of? YES NO
31. Are you troubled by your future plans? YES NO
32. Are you so sad sometimes you think about dying or hurting yourself? YES NO
33. Are you concerned you might have an STD? YES NO
34. Do you have any other personal problems that you would like to discuss with the doctor but rather not write down? YES NO

35. How good is your health?

1	2	3	4	5	6	7	9	9	10
TERRIBLE									GREAT

36. How do you get along with your parents/spouse (if applicable)?

1	2	3	4	5	6	7	8	9	10
TERRIBLE									GREAT

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Date:____/____/______

Any prior history or concerns about Attention Deficit Hyperactivity Disorder (ADHD)?

____

____

When was your last visit to the dentist? ____

Were there any problems that needed treatment? If so, what were they?

FEMALES:

How old were you when your periods began? _______________________________

When was your last period? _______________________________

About how often do you have a period? ________________________________

How long do they usually last? ________________________________

Do you have cramps with your period? YES NO

How do you treat the cramps? ____

Have you ever lost your period for 3 or more months? YES NO

Have you ever had an abnormal Pap smear? YES NO

If so, when and how was it treated?

____

Have you ever had a significant vaginal discharge or been treated for female disorders? YES NO

Have you ever been told that you have an STD or treated for one? YES NO

Do you think you might be pregnant? YES NO

Have you ever been pregnant? YES NO

Are you using birth control? YES NO

If so, what kind?

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Diet History

Name: __________________________ Date: ______________________

Please list any and all food that you actually ate during the 24-hour period yesterday (even if you purged after eating it). If you ate after midnight the day before yesterday, that, would count in yesterday's food.

Quantify the amounts as accurately as possible. Please note that there is a separate column for fluids (this includes any liquids, such as water, milk, shakes, etc.).

Foods	Quantity	Fluids	Quantity
_____________	_________	____________	________
_____________	_________	____________	________
_____________	_________	____________	________
_____________	_________	____________	________
_____________	_________	____________	________
_____________	_________	____________	________
_____________	_________	____________	________
_____________	_________	____________	________
_____________	_________	____________	________
_____________	_________	____________	________
_____________	_________	____________	________

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Name:________________________________ Date:_____________

Exercise History

Over the last week, how much have you exercised?

Please list the type of exercise, what time of day you do the activity, the duration each time, and the intensity of the workout.

For example, "Wed., 7AM, ran 6 miles at a 7 minute pace." Or, "Tuesday, bedtime, 200 crunches to fatigue." If no exercise in the past week, then indicate that also.

Day of week	Time of day	Type of exercise	Duration	Intensity
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

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Current Symptoms

Name: ___________________________ Date: _____________________ Age: ______

The following is a list of symptoms or complaints you may or may not have. Please read each one and check any and all items that apply, even if they may not have changed since y our last visit. **This is CONFIDENTIAL.** Please fold it over when done and hand it to the therapist or receptionist when you are ready to be seen.

_____ Feeling cold much of the time
_____ Fingers or toes turn blue at times
_____ Having "hot flashes" or sweating spells (at night or other times not related to exercise)
_____ Dizziness or feeling like you're going to pass out at times
_____ Your mouth feels dry at times
_____ Chew gum frequently
_____ Your heart beat going fast suddenly
_____ Feeling your heart "skip beats" or like it "jumps" at times
_____ Chest pain
_____ Shortness of breath or trouble breathing recently
_____ Difficulty thinking straight or remembering things as well recently
_____ Trouble falling or staying asleep
_____ Swelling in your feet or hands
_____ Stomach hurting some
_____ Blood when you have thrown up or gone to the bathroom
_____ Noticing something that looks like coffee grounds when you have thrown up
_____ Cutting on yourself some
_____ Pain in one or more of your bones (like your shin or feet) or joints
_____ I have thrown up at least once recently
_____ I have taken some laxatives recently
_____ I have taken some diet pills recently
_____ I have taken stuff to make me throw up
_____ I have taken some water pills recently
_____ I have been drinking alcohol enough to get drunk recently
_____ I have taken other stuff that I would rather not talk about
_____ I have thought about hurting or killing myself recently

__________About how many calories a day have you been eating for the last week (on average)
__________I have no idea how many calories I have been eating (check here if you cannot answer the above question).
__________About how much fluid (water, milk, etc.) have you consumed in the last day? Give an idea of the amount in either ounces, cups, or 8 oz. glasses).

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