campus HEALTH

Date completed: _____/_____/_____

PERSONAL INFORMATION

Legal Name *(Last, First, MI)*: _____ DOB: ___ /____/____ PID: _____

Preferred Name: _____ Pronouns: _____

Sex assigned at birth: ○ Female ○ Male ○ Intersex / Ambiguous

How do you describe yourself? ○ Female ○ Male ○ Trans Female ○ Trans Male ○ Genderqueer / non-conforming

○ Other *(please specify)*:_____ ○ Prefer not to respond

Reason for visit today: _____

MEDICATIONS List with doses. Include contraceptives (pill, IUD, Nexplanon), vitamins, supplements, etc. ○ None

_____ _____

_____ _____

_____ _____

ALLERGIES List medication, food, insect or latex allergies and the type of reaction you had ○ I have no allergies

_____ _____

_____ _____

SURGERIES AND HOSPITALIZATIONS List what types and dates ○ None

_____ _____

_____ _____

SOCIAL HISTORY AND EXERCISE

Alcohol

Do you ever drink alcohol? ○ No ○ Yes, how many times a week? _____

Please indicate the quantity per sitting of each:

Glasses of wine: _____ Can/bottles of beer: _____

Shots of liquor: _____ Drinks containing 0.5 oz of alcohol: _____

Drugs and tobacco

Do you use, or have you ever used drugs? ○ No ○ Yes, what type of drug(s): _____

Check one of the following about smoking tobacco: ○ Never smoked ○ Exposed to secondhand smoke ○ Former smoker ○ Smoke some days ○ Smoke daily

Check one of the following about smokeless tobacco: ○ Never used ○ Former user ○ Current user

Do you use e-cigarettes? ○ No ○ Used in the past ○ Not presently ○ Occasionally ○ Daily

Routine Exercise/Movement (including walking) (Note type, how often, and duration)

_____

_____

_____

YOUR MEDICAL CONDITIONS (check all that apply)

- ☐ Anemia
- ☐ Anxiety/Depression/Bipolar
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Cancer *(type)* _____
- ☐ Crohn's or Ulcerative Colitis
- ☐ Diabetes mellitus (type) ____
- ☐ DVT or PE
- ☐ Eating disorder
- ☐ Epilepsy (Seizures)
- ☐ Heart disease or condition
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney stone or disease
- ☐ Liver disease, hepatitis, tumor
- ☐ Migraine headaches
- ☐ Thyroid disorder
- ☐ Other:_____

DIET

Do you have any dietary restrictions? ◯ Yes ◯ No

If yes, describe: _____
_____

Do you experience or anxiety, fear, guilt, or shame around food ◯ Yes ◯ No

If yes, describe: _____
_____

What did you eat and drink yesterday?

Time	Type of food/drink and Amount Consumed
eg. 8a	Plain bagel with about 2 tablespoons of peanut butter + 1 banana + 1 glass water

Eating Attitudes Test (EAT-26)©

Instructions: This is a screening measure to help you determine whether you might have an eating disorder that needs professional attention. This screening measure is not designed to make a diagnosis of an eating disorder or take the place of a professional consultation. Please fill out the below form as accurately, honestly and completely as possible. There are no right or wrong answers. All of your responses are confidential.

Part A: Complete the following questions:

1) Birth Date	Month:	Day:	Year:	2) Gender:	
3) Height	Feet :	Inches:			
4) Current Weight (lbs.):		5) Highest Weight (excluding pregnancy):			
6) Lowest Adult Weight:		7: Ideal Weight:			

Part B: Check a response for each of the following statements:		Always	Usually	Often	Some times	Rarely	Never
1.	Am terrified about being overweight.	□	□	□	□	□	□
2.	Avoid eating when I am hungry.	□	□	□	□	□	□
3.	Find myself preoccupied with food.	□	□	□	□	□	□
4.	Have gone on eating binges where I feel that I may not be able to stop.	□	□	□	□	□	□
5.	Cut my food into small pieces.	□	□	□	□	□	□
6.	Aware of the calorie content of foods that I eat.	□	□	□	□	□	□
7.	Particularly avoid food with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)	□	□	□	□	□	□
8.	Feel that others would prefer if I ate more.	□	□	□	□	□	□
9.	Vomit after I have eaten.	□	□	□	□	□	□
10.	Feel extremely guilty after eating.	□	□	□	□	□	□
11.	Am preoccupied with a desire to be thinner.	□	□	□	□	□	□
12.	Think about burning up calories when I exercise.	□	□	□	□	□	□
13.	Other people think that I am too thin.	□	□	□	□	□	□
14.	Am preoccupied with the thought of having fat on my body.	□	□	□	□	□	□
15.	Take longer than others to eat my meals.	□	□	□	□	□	□
16.	Avoid foods with sugar in them.	□	□	□	□	□	□
17.	Eat diet foods.	□	□	□	□	□	□
18.	Feel that food controls my life.	□	□	□	□	□	□
19.	Display self-control around food.	□	□	□	□	□	□
20.	Feel that others pressure me to eat.	□	□	□	□	□	□
21.	Give too much time and thought to food.	□	□	□	□	□	□
22.	Feel uncomfortable after eating sweets.	□	□	□	□	□	□
23.	Engage in dieting behavior.	□	□	□	□	□	□
24.	Like my stomach to be empty.	□	□	□	□	□	□
25.	Have the impulse to vomit after meals.	□	□	□	□	□	□
26.	Enjoy trying new rich foods.	□	□	□	□	□	□

Part C: Behavioral Questions: In the past 6 months have you:		Never	Once a month or less	2-3 times a month	Once a week	2-6 times a week	Once a day or more
A	Gone on eating binges where you feel that you may not be able to stop? *	□	□	□	□	□	□
B	Ever made yourself sick (vomited) to control your weight or shape?	□	□	□	□	□	□
C	Ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?	□	□	□	□	□	□
D	Exercised more than 60 minutes a day to lose or to control your weight?	□	□	□	□	□	□
E	Lost 20 pounds or more in the past 6 months	Yes □		No □			

* Defined as eating much more than most people would under the same circumstances and feeling that eating is out of control