Living Hope
Eating Disorder Treatment Center

Residential Treatment Center History and Physical

PATIENT NAME: _____ DATE OF BIRTH: _____

WEIGHT IN GOWN: _____ HEIGHT: _____

***NOTE: If you plan to return this form directly to the patient, please leave "WEIGHT IN GOWN" blank and fax their weight to our main location at 405.801.2366.*

CC: Patient needs clearance for admission to receive treatment for an eating disorder. Please complete and fax this form to 405.801.2366.

HPI:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY: SURGICAL HISTORY/HOSPITALIZATIONS:

Eyes:

_____

_____

HEENT:

_____

_____

Cardiovascular:

_____

_____

Respiratory:

_____

_____

Gastrointestinal:

_____

_____

Genitourinary:

_____

_____

Musculoskeletal:

_____

_____

Integumentary/Breast:

_____

_____

Reproductive:

_____

_____

Neurological/Seizure:

_____

_____

Psychiatric:

_____

_____

Endocrine/Metabolic Disease:

_____

_____

Hematologic/lymphatic:

_____

_____

Allergic/immunologic:

_____

_____

Sleep Disorder:

_____

_____

Renal:

_____

_____

Other:

_____

_____

SURGICAL HISTORY/HOSPITALIZATIONS:

Date: _____ Reason/Procedure: _____

Date: _____ Reason/Procedure: _____

Date: _____ Reason/Procedure: _____

Date: _____ Reason/Procedure: _____

Date: _____ Reason/Procedure: _____

Date: _____ Reason/Procedure: _____

Date: _____ Reason/Procedure: _____

Date: _____ Reason/Procedure: _____

Date: _____ Reason/Procedure: _____

Date: _____ Reason/Procedure: _____

SOCIAL HISTORY:

Tobacco use? ☐ Yes ☐ No
If yes, what type, amount, frequency, and length of use?

_____

_____

_____

Alcohol use? ☐ Yes ☐ No
If yes, what type, amount (number of drinks), frequency, and length of use?

_____

_____

_____

Illicit drug use/prescription drug abuse? ☐ Yes ☐ No
If yes, what type, amount, frequency, length of use, and last use?

_____

_____

_____

_____

Caffeine intake? ☐ Yes ☐ No
If yes, type and amount consumed per day:

_____

_____

_____

EXERCISE HISTORY:
*Please list all exercise done in the last week, including length and intensity of each activity. If needed, please use space below to elaborate.*

☐ I did not exercise over the last week.

| | EXERCISE ACTIVITY | LENGTH | INTENSITY | TIME OF DAY |
|---|---|---|---|---|
| EXAMPLE: | Running | 5 miles in 35 min. | Moderate | 7 a.m. |
| SUNDAY: | | | | |
| MONDAY: | | | | |
| TUESDAY: | | | | |
| WEDNESDAY: | | | | |
| THURSDAY: | | | | |
| FRIDAY: | | | | |
| SATURDAY: | | | | |

## ALLERGIES:

***NOTE: For food allergies, we require allergy testing with documentation, in order to make specific food accommodations for patients.*

Foods:

_____

_____

_____

_____

Medication (date and reaction):

_____

_____

_____

_____

Environmental (date and reaction):

_____

_____

_____

_____

## IMMUNIZATIONS:

*Please list the date that each immunization was received and/or attached immunization records.*

| Immunization Type | Date Received |
|---|---|
| Hep A | |
| Hep B | |

| Immunization Type | Date Received |
|---|---|
| MMR | |
| DTaP | |

| Immunization Type | Date Received | Lot # | Result |
|---|---|---|---|
| TB/PPD | | | |
| Interferon Gold | | N/A | |

MEDICATION:

*Please list all medications you are currently taking below and be sure to complete the chart in its entirety. If more room is needed, please use the back of this page.*

| Name of Medication | Dosage | Route | Frequency | Indication | Continue/ Discontinue/Change |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
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| | | | | | |
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REVIEW OF SYSTEMS:

Constitutional:

☐ Weight loss ☐ Fatigue/Malaise/Lethargy ☐ Insomnia ☐ Hypersomnia/narcolepsy
☐ Night sweats ☐ Unexplained falls ☐ Fever ☐ Dizziness
☐ Visual changes ☐ Blurry vision/Double vision ☐ Redness
☐ Weight Change

_____ Up in _____ weeks/months

_____ Down in _____ weeks/months

Eyes:

☐ Blurring Vision ☐ Double Vision ☐ Redness

HEENT:

☐ Head trauma ☐ Hearing loss ☐ Ringing ☐ Pain in ears/sinuses
☐ Bleeding gums ☐ Epistaxis ☐ Toothaches/Cavities
☐ Difficulty swallowing/pain with swallowing
☐ Other dental issues

Cardiovascular:
☐ Chest pain ☐ Palpitations ☐ Tachycardia/Heart racing ☐ Hypertension
☐ Hypotension ☐ Edema ☐ Orthostatic hypotension ☐ Faintness
☐ SHOB with exercise

Respiratory:
☐ Coughing ☐ SHOB ☐ Wheezing ☐ Difficulty breathing at night

Gastrointestinal:
☐ Abdominal pain ☐ Diarrhea ☐ Constipation ☐ Hematemesis
☐ Melena ☐ GERD ☐ Bloating ☐ Nausea
☐ Vomiting ☐ BRBPR

Genitourinary:
☐ Frequency ☐ Dysuria ☐ Hematuria ☐ Nocturia
☐ Incontinence ☐ Irregular menstruation ☐ Impotence
☐ Amenorrhea
Date of LMP: _____

Musculoskeletal:
☐ Muscle Pain ☐ Joint Pain ☐ Bone Pain ☐ Arthritis
☐ Weakness ☐ Muscle Cramps ☐ Back Pain ☐ Osteoporosis

Integumentary/Breast:
☐ Rash ☐ Pruritis ☐ Lesions ☐ Self-harm/Cutting/Burning
☐ Incisions ☐ Wounds ☐ Dryness ☐ Lesions
☐ Breast pain ☐ Breast augmentation ☐ Breast reduction ☐ Color change
☐ Breast lumps/discharge ☐ Hair loss/thinning

Reproductive:
☐ Pregnant (current)
☐ Pregnant in past
Type of delivery/deliveries: _____
☐ History of abortion

Neurological:
☐ Headaches ☐ Seizures ☐ Lightheadedness ☐ Numbness/Tingling
☐ Memory loss ☐ ADD/ADHD ☐ Tremors ☐ Poor Concentration
☐ Confusion

Psychiatric:
☐ Depression ☐ Anxiety ☐ Panic attacks ☐ Suicidality
☐ Suicide Attempts ☐ Homicidality ☐ Mood Disorder ☐ Mania

Endocrine:
☐ Hormone ☐ Thyroid ☐ DM ☐ Heat Intolerance
☐ Cold Intolerance ☐ Thirsty

Hematologic/lymphatic:
☐ Anemia ☐ Iron Deficiency ☐ Easy Bruising ☐ Slow to Heal
☐ Bleeds Easily ☐ Enlarged Lymph Nodes

Allergic/Immunologic:
☐ Seasonal Allergies ☐ Hives ☐ Anaphylaxis History

PHYSICAL EXAM:
*Please indicate WNL or ABN for each vital sign listed below and document abnormal findings in detail. Orthostatic vital signs are required.*

Vitals:
BP lying: _____ BP sitting: _____ BP standing: _____
P lying: _____ P sitting: _____ P standing: _____
Height: _____ Weight: _____ BMI: _____
Temperature: _____ Respirations: _____ PO2: _____

Evaluation:
Developmental: _____
Nutrition: _____
Grooming: _____
General: _____
HEENT: _____
Neck: _____
Chest/Lungs: _____
Heart: _____
Abdomen: _____
Back: _____
Extremities: _____
Neuro: _____
Skin: _____

Pulses: _____

Teeth: _____

Genital/Rectal: _____

Psych: _____

ASSESSMENT:

Recommendations/Concerns:

_____

_____

_____

_____

_____

_____

_____ Based on my physical exam, review of labs, review of ECG, and clinical judgement, I declare this patient medically stable, free of contagious disease, and safe to participate in residential treatment for their eating disorder at Living Hope EDTC at an ambulatory, mental health facility with 24/7 direct nursing care.

_____ Based on my physical exam, review of labs, review of ECG, and clinical judgement, I feel this patient requires medical stabilization prior to starting treatment at the residential level of care, which is an ambulatory, mental health facility with 24/7 direct nursing care.

Signature: _____ Date: _____