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

Patient History Form for Parent (if applicable)

Patient's Name: ______________________________________ Date: ______/_______/______

1. How did you hear about Dr. Tyson?
____

2. What problem(s) is your daughter/son having?
____
____
____

3. Have there been any changes in the family such as:
_______Marriage _______Divorce ______Births _______Deaths
_______Loss of job _______Move to a new home _______NO CHANGES

If yes, please explain:

4. Father's (or stepfather's) occupation:

5. Mother's (or stepmother's) occupation:

6. Highest grade completed by: Father (Stepfather): ___________________________________
Mother (Stepmother):__________________________________

7. List all brothers and sisters:

NAME	AGE	Highest school grade COMPLETED	HEALTH	WHERE LIVES

PAST MEDICAL HISTORY

8. How old was the patient's mother when she/he was born? ____________
9. Were there any difficulties or problems with pregnancy, labor, or delivery? YES NO
If yes, what:
____

10. What was her/his behavior and development like?
Birth through 1 year:

3 to 6 years:
____

6 to 12 years:
____

© Copyright 2010 Dr. Edward P Tyson, MD

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

Date: ______/_______/______

11. Has she/he ever been hospitalized? _______YES _______NO
    If yes, when and for what:

WHEN	REASON
____________________________	____
____________________________	____

12. Has she/he ever had any of the following illnesses or problems? Circle Y for YES and N for NO:

	YES	NO	When Describe
Hepatitis	Y	N	________________________________
Epilepsy	Y	N	________________________________
Rheumatic fever	Y	N	________________________________
TB	Y	N	________________________________
Mononucleosis	Y	N	________________________________
Diabetes	Y	N	________________________________
Asthma	Y	N	________________________________
Cancer	Y	N	________________________________
Thyroid disease	Y	N	________________________________
Kidney/urinary problems	Y	N	________________________________
Eye/Vision problems	Y	N	________________________________
Joint pain	Y	N	________________________________
Menstrual problems	Y	N	________________________________
Stomach/intestine problems	Y	N	________________________________
Migraines	Y	N	________________________________
Chest pain	Y	N	________________________________
Weight loss	Y	N	________________________________
Depression	Y	N	________________________________
Drug/Alcohol use	Y	N	________________________________
Neck or back pain	Y	N	________________________________
Fainting	Y	N	________________________________
Cold all the time	Y	N	________________________________

13. Does she/he wear a seat belt? Always Some of the time Never

14. Does she/he drive? Yes No

15. Does she/he ride a motorcycle? Yes No
    If so, does she/he wear a helmet? Yes No
16. Do you think she/he is (or has been) sexually active? Yes No Not sure
    If so, do you think she/he practices birth control? Yes No Not sure
    Do you think she/he uses condoms? Yes No Not sure

17. Has she/he had any trauma or sports injuries (include any concussions)? Yes No
    If yes: WHEN? WHAT HAPPENED?

© Copyright 2010 Dr. Edward P Tyson, MD

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

Date: ______/_______/______

18. Immunization History:

	YES	NO	DATES
DPT-Series	______	______	____________________________
Tetanus	______	______	____________________________
Polio	______	______	____________________________
Measles	______	______	____________________________
Rubella (German measles)	______	______	____________________________
Mumps	______	______	____________________________
Varicella	______	______	____________________________
Hepatitis A	______	______	____________________________
Hepatitis B	______	______	____________________________

TB Test Date_____________ Positive ______ Negative___ Unknown_______

19. List all medications (including "over-the-counter" meds), dosage, and the reason taken:

MEDICATION DOSAGE REASON

20. List any and all allergies to any medications that the patient has and what happened:

MEDICATION KIND OF REACTION

GENERAL ADJUSTMENT

21. Describe your daughter's/son/s behavior:

22. How is she/he doing in school? List any specific problems:

23. How does she/he get along with people in general?

24. What does she/he like to do best?

25. What does she/he like to do the least?

26. Has she/he had any jobs? If so, how has she/he performed?

© Copyright 2010 Dr. Edward P Tyson, MD

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

Date: ______/_______/______

FAMILY HISTORY

Have any members of the patient's natural family, alive or dead, had any of the following problems? If YES, please state the age of the person when the condition occurred and the relationship of this person to the patient.

	YES	NO	Relation to patient
A. Alcoholism/Drug Problems	Y	N	______________________
B. Allergies/Asthma	Y	N	______________________
C. Arthritis	Y	N	______________________
D. Cancer	Y	N	______________________
E. Diabetes	Y	N	______________________
F. Emotional Problems/Suicide	Y	N	______________________
G. Eating Disorders	Y	N	______________________
H. Hormone Problems	Y	N	______________________
I. Heart attack or stroke before age 55	Y	N	______________________
J. High blood pressure	Y	N	______________________
K. Kidney/Liver/Lung Disease	Y	N	______________________
L. Mental Retardation/Birth Defects	Y	N	______________________
M. Migraines	Y	N	______________________
N. Obesity	Y	N	______________________
O. Seizure Disorder	Y	N	______________________

Do you have any concerns about your daughter/son about:

	YES	NO		YES	NO
Alcohol	Y	N	Birth Control	Y	N
Drugs	Y	N	Friends	Y	N
Smoking	Y	N	Activities	Y	N
Dating	Y	N	School	Y	N
Sex	Y	N			

Describe any unusual behavior or personality problems:

____

Please discuss any other concerns:

____
____
____
____
____
____

© Copyright 2010 Dr. Edward P Tyson, MD