EDQ

Version 9.0

INSTRUCTIONS: Please fill in the circle that best describes you for each item.

A. DEMOGRAPHIC INFORMATION

1. Sex: ○ Female ○ Male

2. Current Age: _____ years

   Date of Birth:

   ☐☐ / ☐☐ / ☐☐☐☐

3. Race (fill in only one):
   - ○ White
   - ○ African American
   - ○ Native American
   - ○ Hispanic
   - ○ Asian
   - ○ Other (please specify) _____

4. Marital Status (fill in only one):
   - ○ Never married
   - ○ Married (first marriage)
   - ○ Divorced or widowed and presently remarried
   - ○ Monogamous relationship, living with partner (but not married)
   - ○ Monogamous relationship, not living with partner
   - ○ Divorced and not presently married
   - ○ Widowed and not presently remarried

5. What is your primary role? (fill in only one)
   - ○ Wage earner, full-time
   - ○ Wage earner, part-time
   - ○ Student, full-time
   - ○ Student, part-time
   - ○ Homemaker
   - ○ Unemployed
   - ○ Other (specify) _____

B. WEIGHT HISTORY

1. Current Weight: ☐☐☐ lbs.

2. Current Height: ☐ ft. ☐☐ in.

3. I would like to weigh: ☐☐☐ lbs.

4. **Highest Weight** (non-pregnancy) since age 18:

   Weight ☐☐☐ lbs. **at** **Age** ☐☐ yrs.

5. **Lowest Weight** since age 18:

   Weight ☐☐☐ lbs. **at** **Age** ☐☐ yrs.

6. **Highest Weight between ages 12 and 18:**

   Weight ☐☐☐ lbs. **at** **Height** ☐ ft. ☐☐ in. **at age**
   - ○ 12
   - ○ 13
   - ○ 14
   - ○ 15
   - ○ 16
   - ○ 17

7. **Lowest Weight between ages 12 and 18:**

   Weight ☐☐☐ lbs. **at** **Height** ☐ ft. ☐☐ in. **at age**
   - ○ 12
   - ○ 13
   - ○ 14
   - ○ 15
   - ○ 16
   - ○ 17

8. At your current weight, do you feel that you are:
   - ○ Extremely thin
   - ○ Moderately thin
   - ○ Slightly thin
   - ○ Normal weight
   - ○ Slightly overweight
   - ○ Moderately overweight
   - ○ Extremely overweight

9. How much do you fear gaining weight?
   - ○ Not at all
   - ○ Slightly
   - ○ Moderately
   - ○ Very much
   - ○ Extremely

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10. How dissatisfied are you with the way your body is proportioned?

- ○ Not at all dissatisfied
- ○ Slightly dissatisfied
- ○ Moderately dissatisfied
- ○ Very dissatisfied
- ○ Extremely dissatisfied

11. How important is your weight and shape in affecting how you feel about yourself as a person?

- ○ Not at all important
- ○ Slightly important
- ○ Moderately important
- ○ Very important
- ○ Extremely important

12. How fat do you currently feel?

- ○ Not at all fat
- ○ Slightly fat
- ○ Fat
- ○ Very fat
- ○ Extremely fat

13. **Please indicate on the scales below how you feel about different areas of your body.**
(Fill in the circle of best response for each body part.)

	(a) Face	(b) Arms	(c) Shoulders	(d) Breasts	(e) Stomach	(f) Waist	(g) Hips	(h) Buttocks	(i) Thighs
Extremely positive	○	○	○	○	○	○	○	○	○
Moderately positive	○	○	○	○	○	○	○	○	○
Slightly positive	○	○	○	○	○	○	○	○	○
Neutral	○	○	○	○	○	○	○	○	○
Slightly negative	○	○	○	○	○	○	○	○	○
Moderately negative	○	○	○	○	○	○	○	○	○
Extremely negative	○	○	○	○	○	○	○	○	○

14. On the average, how often do you weigh yourself?

- ○ Never
- ○ Less than monthly
- ○ Monthly
- ○ Several times/month
- ○ Weekly
- ○ Several times/week
- ○ Daily
- ○ 2 or 3 times/day
- ○ 4 or 5 times/day
- ○ More than 5 times/day

C. DIETING BEHAVIOR

1. On the average, how many main meals do you eat each day?

☐☐

2. On the average, how many snacks do you eat each day?

☐☐

3. On the average, how many days a week do you eat the following meals?

Breakfast: ☐ days a week Lunch: ☐ days a week Dinner: ☐ days a week

4. Do you try to avoid certain foods in order to influence your shape or weight?

- ○ Yes (If Yes, what?) _____
- ○ No

5. Have you ever been on a diet, restricted your food intake, and/or reduced the amounts or types of food eaten to control your weight?

- ○ Yes
- ○ No (If No, go to section D, "BINGE EATING BEHAVIOR.")

6. At what age did you first begin to diet, restrict your food intake, and/or reduce the amount or types of food eaten to control your weight?

☐☐ years old

7. At what age did you first begin to diet, restrict your food intake, and/or reduce the amount or types of food eaten to lose weight?

☐☐ years old

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8. Over the last year, how often have you begun a diet that lasted for more than 3 days?

   ☐☐☐ times

9. Over the last year, how often have you begun a diet that lasted for 3 days or less?

   ☐☐☐ times

10. Indicate your preferred ways of dieting (fill in all that apply).

- ○ Skip meals
- ○ Completely fast for 24 hours or more
- ○ Restrict carbohydrates
- ○ Restrict sweets/sugar
- ○ Reduce fats
- ○ Reduce portion size
- ○ Exercise more
- ○ Reduce calories
- ○ Other: _____

11. In which of the following treatments or types of treatment for eating or weight problems have you participated?

(a) Supervised Diets:	Yes	No	If Yes, ages used	Weight at Start	Weight at End
Weight Watchers ®	○	○			
Jenny Craig ®	○	○			
Nutrasystems ®	○	○			
Optifast ®	○	○			
Procal ®	○	○			
Nutramed ®	○	○			
Liquid protein diet	○	○			
Others: _____	○	○			

(b) Medication for Obesity:	Yes	No	If Yes, ages used	Weight at Start	Weight at End
Phentermine	○	○			
Fenfluramine	○	○			
Xenical (Orlistat ®)	○	○			
Sibutramine (Meridia ®)	○	○			
Topiramate (Topomax ®)	○	○			
Wellbutrin (Buproprion ®)	○	○			
Over-the-counter diet pills (specify): _____	○	○			
Other medication treatment (specify): _____	○	○			
Human Chorionic Gonadotropin (HCG)	○	○			
Others: _____	○	○			

(c) Psychotherapy for Eating Problems, Weight Loss, or Weight Gain:	Yes	No	If Yes, ages used	Weight at Start	Weight at End
Behavior Modification	○	○			
Individual Psychotherapy	○	○			
Group Psychotherapy	○	○			
Hypnosis	○	○			
Others: _____	○	○			

(d) Psychotherapy for Eating Disorder:	Yes	No	If Yes, ages used	Weight at Start	Weight at End
Individual Cognitive Behavioral	○	○			
Group Cognitive Behavioral	○	○			
Interpersonal Psychotherapy	○	○			
Nutritional Counseling	○	○			
Others: _____	○	○			

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(e) Medication for Eating Problems/Weight Problems:	Yes	No	If Yes, ages used	If Yes, maximum dosage
Fluoxetine (Prozac ®)	○	○		
Desipramine (Norpramin ®)	○	○		
Paroxetine HCl (Paxil ®)	○	○		
Sertraline HCl (Zoloft ®)	○	○		
Citalopram (Celexa ®)	○	○		
Fluvoxamine (Luvox ®)	○	○		
Naltrexone (Trexan ®)	○	○		
Escitalopram (Lexapro ®)	○	○		
Quetiapine (Seroquel ®)	○	○		
Olanzapine (Zyprexa ®)	○	○		
Risperidone (Risperidol ®)	○	○		
Others: _____	○	○		

(f) Self-help groups:	Yes	No	If Yes, ages used
Bulimia Anonymous	○	○	
Overeaters Anonymous	○	○	
Anorexics Anonymous	○	○	
Others: _____	○	○	

(g) Surgical Procedures:	Yes	No	If Yes, at what age	Weight at Start	Weight at End
Liposuction	○	○			
Gastric bypass	○	○			
Gastric banding	○	○			
Other intestinal surgery (specify): _____	○	○			
Gastric balloon/"bubble"	○	○			
Others: _____	○	○			

12. Please record your major diets which resulted in a <u>weight loss of 10 pounds or more</u>.

	Age at time of diet	Weight at start of diet	# lbs. lost	Type of diet
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				
(7)				
(8)				
(9)				
(10)				

13. Have you ever had any significant physical or emotional symptoms while attempting to lose weight or after losing weight?

○ Yes ○ No

If Yes, describe your symptoms, how long they lasted, if they made you stop your weight loss program, and if they made you seek professional help.

Problem	Year	Duration (weeks)	Stopped weight loss program? **Yes**	**No**	Type of professional help, if any
			○	○	
			○	○	
			○	○	
			○	○	
			○	○	

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D. BINGE EATING BEHAVIOR

1. Have you ever had an episode of binge eating characterized by:

   (a) eating, in a discrete period of time (e.g., within any two hour period), an amount of food that is definetely larger than most people eat in a similar period of time?
   ○ Yes ○ No

   (b) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)?
   ○ Yes ○ No

   If No to either a) or b), go to section E, "WEIGHT CONTROL BEHAVIOR."

2. Please indicate on the scales below how characteristic the following symptoms are or were of your binge eating.

	Never	Rarely	Sometimes	Often	Always
(a) feeling that I can't stop eating or control what or how much I eat	○	○	○	○	○
(b) eating much more rapidly than usual	○	○	○	○	○
(c) eating until I feel uncomfortably full	○	○	○	○	○
(d) eating large amounts of food when not feeling physically hungry	○	○	○	○	○
(e) eating alone because I am embarrassed by how much I am eating	○	○	○	○	○
(f) feeling disgusted with myself, depressed, or very guilty after overeating	○	○	○	○	○
(g) feeling very distressed about binge eating	○	○	○	○	○

3. How old were you when you began binge eating?

   ☐☐ years old

4. When did binge eating start to occur on a regular basis, on average at at least 2 times each week?

   ☐☐ years old

5. What was your height and weight at that time?

   Weight ☐☐☐ lbs. **at** **Height** ☐ ft. ☐☐ in.

6. What is the total duration of time you had a problem with binge eating (whether or not you are binge eating now)?

   Days ☐☐ **Months** ☐☐ **Years** ☐☐

E. WEIGHT CONTROL BEHAVIOR

1. Have you ever self-induced vomiting after eating in order to get rid of the food eaten?
   ○ Yes ○ No (If No, go to question 8.)

2. How old were you when you induced vomiting for the first time?

   ☐☐ years old

3. How old were you when you first induced vomiting on a regular basis (on average at least two times each week)?

   ☐☐ years old

4. How long did you self-induce vomiting?

   Days ☐☐ **Months** ☐☐ **Years** ☐☐

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5. Have you ever taken syrup of Ipecac ® to control your weight?
   ○ Yes ○ No

6. How old were you when you took Ipecac ® for the first time?
   ☐☐ years old

7. How long did you use Ipecac ® to control your weight?
   Days ☐☐ **Months** ☐☐ **Years** ☐☐

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8. Have you ever used laxatives to control your weight or "get rid of food?"
   ○ Yes ○ No (If No, go to question 13.)

9. How old were you when you first took laxatives for weight control?
   ☐☐ years old

10. How old were you when you first took laxatives for weight control (on a regular basis on average at least two times each week)?
    ☐☐ years old

11. How long did you use laxatives for weight control?
    Days ☐☐ **Months** ☐☐ **Years** ☐☐

12. What type and amounts of laxatives have you used? (Indicate all types that apply and the maximum number used per day.)

	Yes	No	Maximum Number per Day: 1	2	3	4	5	6-10	11-20	>20
Ex-Lax ®	○	○	○	○	○	○	○	○	○	○
Correctol ®	○	○	○	○	○	○	○	○	○	○
Metamucil ®	○	○	○	○	○	○	○	○	○	○
Colace ®	○	○	○	○	○	○	○	○	○	○
Dulcolax ®	○	○	○	○	○	○	○	○	○	○
Phillips Milk of Magnesia ®	○	○	○	○	○	○	○	○	○	○
Senokot ®	○	○	○	○	○	○	○	○	○	○
Perdiem ®	○	○	○	○	○	○	○	○	○	○
Fleet ®	○	○	○	○	○	○	○	○	○	○
Other (specify): _____	○	○	○	○	○	○	○	○	○	○

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13. Have you ever used diuretics (water pills) to control your weight?
    ○ Yes ○ No (If No, go to question 18.)

14. How old were you when you first took diuretics for weight control?
    ☐☐ years old

15. How old were you when you first took diuretics for weight control (on a regular basis, on average at least two times each week)?
    ☐☐ years old

16. How long did you use diuretics for weight control?
    Days ☐☐ **Months** ☐☐ **Years** ☐☐

17. What type and amount of diuretics have you used? (Indicate all that apply and the maximum number used per day.)

(a) Over-the-counter Diuretics:	Yes	No	Maximum Number per Day: 1	2	3	4	5	6	7	8	9	10	>10
Aqua-Ban ®	○	○	○	○	○	○	○	○	○	○	○	○	○
Diurex ®	○	○	○	○	○	○	○	○	○	○	○	○	○
Midol ®	○	○	○	○	○	○	○	○	○	○	○	○	○
Pamprin ®	○	○	○	○	○	○	○	○	○	○	○	○	○
Others (specify): _____	○	○	○	○	○	○	○	○	○	○	○	○	○

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(b) Prescription Diuretics:	Yes	No	Maximum Number per Day 1	2	3	4	5	6	7	8	9	10	>10
	○	○	○	○	○	○	○	○	○	○	○	○	○
	○	○	○	○	○	○	○	○	○	○	○	○	○

18. Have you ever used diet pills to control your weight?
○ Yes ○ No (If No, please go to question 22.)

19. How old were you when you first used diet pills for weight control?

☐☐ years old

20. How long did you use diet pills to control your weight?

Days	Months	Years
☐☐	☐☐	☐☐

21. What types and amounts of diet pills have you used **within the last month**? (Indicate all that apply and the maximum number per day.)

(a) Over-the-counter:	Yes	No	Maximum Number per Day 1	2	3	4	5	6	7	8	9	10	>10
Dexatrim ®	○	○	○	○	○	○	○	○	○	○	○	○	○
Dietac ®	○	○	○	○	○	○	○	○	○	○	○	○	○
Acutrim ®	○	○	○	○	○	○	○	○	○	○	○	○	○
Protrim ®	○	○	○	○	○	○	○	○	○	○	○	○	○
Ma Huang	○	○	○	○	○	○	○	○	○	○	○	○	○
Ephedrine	○	○	○	○	○	○	○	○	○	○	○	○	○
Chromium	○	○	○	○	○	○	○	○	○	○	○	○	○
Guarana seed	○	○	○	○	○	○	○	○	○	○	○	○	○
Garcinia Cambogia	○	○	○	○	○	○	○	○	○	○	○	○	○
Caffeine	○	○	○	○	○	○	○	○	○	○	○	○	○
Other (specify): _____	○	○	○	○	○	○	○	○	○	○	○	○	○

(b) Prescription:	Yes	No	Maximum Number per Day 1	2	3	4	5	6	7	8	9	10	>10
	○	○	○	○	○	○	○	○	○	○	○	○	○
	○	○	○	○	○	○	○	○	○	○	○	○	○

22. During the entire LAST MONTH, what is the average frequency that you have engaged in the following behaviors? (Please fill in one circle for each behavior.)

	Never	Once a Month or Less	Several Times a Month	Once a Week	Twice a Week	Three to Six Times a Week	Once a Day	More Than Once a Day
Binge eating (as defined on pg. 5, D.1.)	○	○	○	○	○	○	○	○
Vomiting	○	○	○	○	○	○	○	○
Laxative use to control weight	○	○	○	○	○	○	○	○
Use of diet pills	○	○	○	○	○	○	○	○
Use of diuretics	○	○	○	○	○	○	○	○
Use of enemas	○	○	○	○	○	○	○	○
Use of Ipecac ® syrup	○	○	○	○	○	○	○	○
Exercise to control weight	○	○	○	○	○	○	○	○
Fasting (skipping meals for entire day)	○	○	○	○	○	○	○	○
Skipping meals	○	○	○	○	○	○	○	○
Eating very small meals	○	○	○	○	○	○	○	○
Eating meals low in calories and/or fat grams	○	○	○	○	○	○	○	○
Chewing and spitting out food	○	○	○	○	○	○	○	○
Rumination (vomit food into mouth, chew, and re-swallow	○	○	○	○	○	○	○	○
Saunas to control weight	○	○	○	○	○	○	○	○
Herbal products ("fat burners")	○	○	○	○	○	○	○	○

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23. During **any one month period**, what is the HIGHEST frequency that you have engaged in the following behaviors? (Please fill in one circle for each behavior.)

	Never	Once a Month or Less	Several Times a Month	Once a Week	Twice a Week	Three to Six Times a Week	Once a Day	More Than Once a Day
Binge eating (as defined on pg. 5, D.1.)	○	○	○	○	○	○	○	○
Vomiting	○	○	○	○	○	○	○	○
Laxative use to control weight	○	○	○	○	○	○	○	○
Use of diet pills	○	○	○	○	○	○	○	○
Use of diuretics	○	○	○	○	○	○	○	○
Use of enemas	○	○	○	○	○	○	○	○
Use of Ipecac ® syrup	○	○	○	○	○	○	○	○
Exercise to control weight	○	○	○	○	○	○	○	○
Fasting (skipping meals for entire day)	○	○	○	○	○	○	○	○
Skipping meals	○	○	○	○	○	○	○	○
Eating very small meals	○	○	○	○	○	○	○	○
Eating meals low in calories and/or fat grams	○	○	○	○	○	○	○	○
Chewing and spitting out food	○	○	○	○	○	○	○	○
Rumination (vomit food into mouth, chew, and re-swallow	○	○	○	○	○	○	○	○
Saunas to control weight	○	○	○	○	○	○	○	○
Herbal products ("fat burners")	○	○	○	○	○	○	○	○

F. EXERCISE

1. How frequently do you exercise?

○ Not at all
○ Once per month or less
○ Several times per month
○ Once per week
○ Several times per week
○ Once per day
○ Several times a day

2. If you exercise, how long do you usually exercise each time?

○ Less than 15 minutes
○ 15 - 30 minutes
○ 31 - 60 minutes
○ 61 - 120 minutes
○ More than 120 minutes

3. If you exercise, please indicate the types of exercise you do (fill in all that apply).

○ Biking
○ Running
○ Swimming
○ Weighttraining
○ Aerobics
○ Calisthenics
○ Walking
○ In-lineskating
○ Stairmaster
○ Treadmill
○ Stationary bike
○ Other: _____

G. MENSTRUAL HISTORY

1. Age of onset of menses: ☐☐ years

2. Have you ever had periods of time when you stopped menstruating for three months or more (which were unrelated to pregnancy)?

○ Yes ○ No If Yes, number of times: ☐☐

3. Did weight loss ever cause irregularities of your cycle?

○ Yes ○ No If Yes, describe:

_____

_____

4. Have you menstruated during the last three months?

○ Yes ○ No

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5. Are you on birth control pills? ○ Yes ○ No

6. Are you on hormone replacement? ○ Yes ○ No

7. Are you post menopausal? ○ Yes ○ No

8. Please indicate when during your cycle you feel most vulnerable to binge eating. Please fill in the single best response.

○ I do not binge eat during menstruation
○ 11 - 14 days prior to menstruation
○ 7 - 10 days prior to menstruation
○ 3 - 6 days prior to menstruation
○ 1 - 2 days prior to menstruation
○ After menstruation onset
○ No particular time

9. Do you crave particular foods (have a desire or urge to consume a specific food item or drink) for the <u>few days prior to</u> menstruation?

○ Yes ○ No If Yes, what foods do you crave?

_____

_____

10. Do you crave particular foods (have a desire or urge to consume a specific food item or drink) <u>during</u> your menstruation?

○ Yes ○ No If Yes, what foods do you crave?

_____

_____

11. Marriage and pregnancy:

	Yes	No	Does Not Apply
(a) Did problems with weight and/or binge eating begin before you were married?	○	○	○
(b) Did problems with weight and/or binge eating begin after you were married?	○	○	○
(c) Did problems with weight and/or binge eating begin before your first pregnancy?	○	○	○
(d) Did problems with weight and/or binge eating begin after your first pregnancy?	○	○	○

12. Do you have children?

○ Yes ○ No (If No, skip to section H, "HISTORY OF ABUSE.")

(a) For your FIRST child, what was your...

...weight at the start of your pregnancy? ☐☐☐

...weight at delivery? ☐☐☐

...lowest weight in the first year after delivery? ☐☐☐

(b) For your SECOND child, what was your...

...weight at the start of your pregnancy? ☐☐☐

...weight at delivery? ☐☐☐

...lowest weight in the first year after delivery? ☐☐☐

(c) For your THIRD child, what was your...

...weight at the start of your pregnancy? ☐☐☐

...weight at delivery? ☐☐☐

...lowest weight in the first year after delivery? ☐☐☐

(d) For your FOURTH child, what was your...

...weight at the start of your pregnancy? ☐☐☐

...weight at delivery? ☐☐☐

...lowest weight in the first year after delivery? ☐☐☐

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H. HISTORY OF ABUSE

1. Before you were 18, did any of the following happen to you?

Yes	No	
○	○	Someone constantly criticized you and blamed you for minor things.
○	○	Someone physically beat you (hit you, slapped you, threw something at you, pushed you).
○	○	Someone threatened to hurt or kill you, or do something sexual to you.
○	○	Someone threatened to abandon or leave you.
○	○	You watched one parent physically beat (hit, slap) the other parent.
○	○	Someone from your family forced you to have sexual relations (unwanted touching, fondling, sexual kissing, sexual intercourse).
○	○	Someone outside your family forced you to have sexual relations (unwanted touching, fondling, sexual kissing, sexual intercourse).

2. After you were 18, did any of the following happen to you?

Yes	No	
○	○	Someone constantly criticized you and blamed you for minor things.
○	○	Someone physically beat you (hit you, slapped you, threw something at you, pushed you).
○	○	Someone threatened to hurt or kill you, or do something sexual to you.
○	○	Someone threatened to abandon or leave you.
○	○	You watched one parent physically beat (hit, slap) the other parent.
○	○	Someone from your family forced you to have sexual relations (unwanted touching, fondling, sexual kissing, sexual intercourse).
○	○	Someone outside your family forced you to have sexual relations (unwanted touching, fondling, sexual kissing, sexual intercourse).

I. PSYCHIATRIC HISTORY

1. Have you ever been hospitalized for psychiatric problems?

○ Yes (If Yes, please complete the section below.)
○ No

HOSPITAL NAME & ADDRESS (CITY, STATE)	WHAT YEAR	DIAGNOSIS (IF KNOWN) OR PROBLEMS YOU WERE HAVING	TREATMENT YOU RECEIVED	WAS THIS HELPFUL? Yes	No
				○	○
				○	○
				○	○
				○	○
				○	○

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2. Have you ever been treated out of the hospital for psychiatric problems?

○ Yes (If Yes, please complete the section below.)

○ No

YEAR(S) WHEN TREATED	DOCTOR OR THERAPIST'S NAME & ADDRESS (CITY, STATE)	DIAGNOSIS (IF KNOWN) OR PROBLEMS YOU WERE HAVING	TREATMENT YOU RECEIVED	WAS THIS HELPFUL? Yes	No
				○	○
				○	○
				○	○
				○	○
				○	○

3. Complete the following information for any of the following types of medications you are now taking or have ever taken:

		Took Previously	On Currently	Current Dosage	If taking currently, for what problem?
(a) ANTIDEPRESSANTS					
Prozac ®	(Fluoxetine)	○	○		
Zoloft ®	(Sertraline)	○	○		
Paxil ®	(Paroxetine)	○	○		
Luvox ®	(Fluvoxamine)	○	○		
Celexa ®	(Citalopram)	○	○		
Effexor ®	(Venlafaxine)	○	○		
Wellbutrin ®	(Bupropion)	○	○		
Elavil ®	(Amitriptyline)	○	○		
Tofranil ®	(Imipramine)	○	○		
Sinequan ®	(Doxepin)	○	○		
Norpramin ®	(Desipramine)	○	○		
Vivactil ®	(Protriptyline)	○	○		
Desyrel ®	(Trazodone)	○	○		
Parnate ®	(Tranylcypromine)	○	○		
Nardil ®	(Phenelzine)	○	○		
Anafranil ®	(Clomipramine)	○	○		
Remeron ®	(Mirtazapine)	○	○		
Serzone ®	(Nefazodone)	○	○		
St. John's Wort		○	○		
Lexapro ®	(Escitalopram)	○	○		
(b) MAJOR TRANQUILIZERS					
Clozaril ®	(Clozapine)	○	○		
Zyprexa ®	(Olanzepine)	○	○		
Risperdal ®	(Risperidone)	○	○		
Haldol ®	(Haloperidol)	○	○		
Navane ®	(Thiothixene)	○	○		
Trilafon ®	(Perphenazine)	○	○		
Thorazine ®	(Chlorpromazine)	○	○		
Stelazine ®	(Trifluoperazine)	○	○		
Prolixin ®	(Fluphenazine)	○	○		
Orap ®	(Pimozide)	○	○		
Moban ®	(Molindone)	○	○		
Loxitane ®	(Loxapine)	○	○		
Seroquil ®	(Quetiapine)	○	○		
Mellaril ®	(Thioridazine)	○	○		
Geodon ®	(Ziprasidone)	○	○		
Abilify ®	(Aripiprozole)	○	○		

Continue on Next Page

		Took Previously	On Currently	Current Dosage	If taking currently, for what problem?
(c) MINOR TRANQUILIZERS					
Valium ®	(Diazepam)	○	○		
Librium ®	(Chlordiazepoxide)	○	○		
Serax ®	(Oxazepam)	○	○		
Halcion ®	(Triazolam)	○	○		
Tranxene ®	(Clorazepate)	○	○		
Ambien ®	(Zolpidem)	○	○		
Klonopin ®	(Clonazepam)	○	○		
Ativan ®	(Lorazepam)	○	○		
BuSpar ®	(Buspirone)	○	○		
Dalmane ®	(Flurazepam)	○	○		
Xanax ®	(Alprazolam)	○	○		
Sonata ®	(Zaleplon)	○	○		
(d) MOOD STABILIZERS					
Lithobid ®	Lithium ®	○	○		
Depakote ®	Sodium Valproate ®	○	○		
Tegretol ®	(Carbamazepine)	○	○		
Topomax ®	(Topiramate)	○	○		
Lamictal ®	(Lamotrigine)	○	○		
OTHER:		○	○		
OTHER:		○	○		
OTHER:		○	○		
OTHER:		○	○		

J. MEDICAL HISTORY

1. Please list all medical hospitalizations:

WHEN? YEAR(S)	WHERE? (Hospital Name & City)	PROBLEM	DIAGNOSIS	TREATMENT YOU RECEIVED

2. Please list all other medical treatment you've received. (Include any significant problem, but do not include flu, colds, routine exams.)

WHEN? YEAR(S)	WHERE? (Doctor's Name & Address)	PROBLEM	DIAGNOSIS	TREATMENT YOU RECEIVED

Continue on Next Page

K. CHEMICAL USE HISTORY

1. In the last six months, how often have you taken these drugs?

	Not At All	Less Than Monthly	About Once a Month	Several Times a Month	About Once a Week	Several Times a Week	Daily	Several Times a Day
ALCOHOL	○	○	○	○	○	○	○	○
STIMULANTS (Amphetamines, Uppers, Crank, Speed)	○	○	○	○	○	○	○	○
DIET PILLS	○	○	○	○	○	○	○	○
SEDATIVES (Barbiturates, Sleeping Pills, Valium ®, Librium ®, Downers)	○	○	○	○	○	○	○	○
MARIJUANA/HASHISH	○	○	○	○	○	○	○	○
HALLUCINOGENS (LSD, Mescaline, Mushrooms, Extasy)	○	○	○	○	○	○	○	○
OPIATES (Heroin, Morphine, Opium)	○	○	○	○	○	○	○	○
COCAINE/CRACK	○	○	○	○	○	○	○	○
PCP (Angel Dust, Phencyclidine)	○	○	○	○	○	○	○	○
INHALANTS (Glue, Gasoline, etc.)	○	○	○	○	○	○	○	○
CAFFEINE PILLS (No Doz ®, Vivarin ®, etc.)	○	○	○	○	○	○	○	○
OTHER: _____	○	○	○	○	○	○	○	○
_____	○	○	○	○	○	○	○	○

2. What is the most you have used any of these drugs during a one-month period (month of heaviest use)?

(Example: If you used sleeping pills about once a month many years ago, but not at all now, you would fill in the circle under "About Once a Month" on the line "Sedatives - Barbiturates...")

	Not At All	Less Than Monthly	About Once a Month	Several Times a Month	About Once a Week	Several Times a Week	Daily	Several Times a Day
ALCOHOL	○	○	○	○	○	○	○	○
STIMULANTS (Amphetamines, Uppers, Crank, Speed)	○	○	○	○	○	○	○	○
DIET PILLS	○	○	○	○	○	○	○	○
SEDATIVES (Barbiturates, Sleeping Pills, Valium ®, Librium ®, Downers)	○	○	○	○	○	○	○	○
MARIJUANA/HASHISH	○	○	○	○	○	○	○	○
HALLUCINOGENS (LSD, Mescaline, Mushrooms, Extasy)	○	○	○	○	○	○	○	○
OPIATES (Heroin, Morphine, Opium)	○	○	○	○	○	○	○	○
COCAINE/CRACK	○	○	○	○	○	○	○	○
PCP (Angel Dust, Phencyclidine)	○	○	○	○	○	○	○	○
INHALANTS (Glue, Gasoline, etc.)	○	○	○	○	○	○	○	○
CAFFEINE PILLS (No Doz ®, Vivarin ®, etc.)	○	○	○	○	○	○	○	○
OTHER: _____	○	○	○	○	○	○	○	○
_____	○	○	○	○	○	○	○	○

3. Assuming all the drugs mentioned above were readily available, which would you prefer? _____

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Have you ever had any of the following problems because of your alcohol or drug use? (if Yes, please specify.)

4. Drinking and driving when unsafe?
   - ○ Yes.....When?
     - ○ More than 6 months ago
     - ○ During the past 6 months
     - ○ Both
   - ○ No

5. Medical problems?
   - ○ Yes.....When?
     - ○ More than 6 months ago
     - ○ During the past 6 months
     - ○ Both
   - ○ No

6. Problems at work or school?
   - ○ Yes.....When?
     - ○ More than 6 months ago
     - ○ During the past 6 months
     - ○ Both
   - ○ No

7. An arrest?
   - ○ Yes.....When?
     - ○ More than 6 months ago
     - ○ During the past 6 months
     - ○ Both
   - ○ No

8. Family trouble?
   - ○ Yes.....When?
     - ○ More than 6 months ago
     - ○ During the past 6 months
     - ○ Both
   - ○ No

---

9. Have you ever smoked cigarettes?
   - ○ Yes
   - ○ No (If No, go to question 10.)

   What was the most you ever smoked?
   - ○ Only occasionally
   - ○ Less than one pack per day
   - ○ About one pack per day
   - ○ One to two packs per day
   - ○ About two packs per day
   - ○ More than two packs per day

   If you are smoking now, how much do you smoke?
   - ○ Only occasionally
   - ○ Less than one pack per day
   - ○ About one pack per day
   - ○ One to two packs per day
   - ○ About two packs per day
   - ○ More than two packs per day

---

10. Do you drink coffee?
    - ○ Yes
    - ○ No (If No, go to question 11.)

    On the average, how many cups of caffeinated coffee do you drink per day?
    - ○ Less than 1
    - ○ 1 cup per day
    - ○ 2 cups
    - ○ 3 cups
    - ○ 4 cups
    - ○ 5 cups
    - ○ 6 - 10 cups
    - ○ More than 10 cups

    On the average, how many cups of decaffeinated coffee do you drink per day?
    - ○ Less than 1
    - ○ 1 cup per day
    - ○ 2 cups
    - ○ 3 cups
    - ○ 4 cups
    - ○ 5 cups
    - ○ 6 - 10 cups
    - ○ More than 10 cups

---

11. Do you drink tea?
    - ○ Yes
    - ○ No (If No, go to question 12.)

    On the average, how many cups of caffeinated tea do you drink per day?
    - ○ Less than 1
    - ○ 1 cup per day
    - ○ 2 cups
    - ○ 3 cups
    - ○ 4 cups
    - ○ 5 cups
    - ○ 6 - 10 cups
    - ○ More than 10 cups

    On the average, how many cups of decaffeinated tea do you drink per day?
    - ○ Less than 1
    - ○ 1 cup per day
    - ○ 2 cups
    - ○ 3 cups
    - ○ 4 cups
    - ○ 5 cups
    - ○ 6 - 10 cups
    - ○ More than 10 cups

---

12. Do you drink cola or soft drinks?
    - ○ Yes
    - ○ No (If No, go to next section.)

    On the average, how many cans/glasses of caffeinated cola or soft drinks do you drink per day?
    - ○ Less than 1
    - ○ 1 can per day
    - ○ 2 cans
    - ○ 3 cans
    - ○ 4 cans
    - ○ 5 cans
    - ○ 6 - 10 cans
    - ○ More than 10 cans

    On the average, how many cans/glasses of decaffeinated cola or soft drinks do you drink per day?
    - ○ Less than 1
    - ○ 1 can per day
    - ○ 2 cans
    - ○ 3 cans
    - ○ 4 cans
    - ○ 5 cans
    - ○ 6 - 10 cans
    - ○ More than 10 cans

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L. FAMILY MEMBERS

1.

	NAME	AGE IF LIVING	CAUSE OF DEATH	AGE AT DEATH
FATHER				
MOTHER				
BROTHERS & SISTERS				
SPOUSE				
CHILD 1				
CHILD 2				
CHILD 3				
CHILD 4				

2. Are you a twin? ○ Yes ○ No

(If Yes, is your twin identical? ____Yes ____No)

3. Were you adopted? ○ Yes ○ No

(If Yes, at what age were you adopted? _____)

M. FAMILY MEDICAL AND PSYCHIATRIC HISTORY

1. Fill in the circle in the column of any of your *blood relatives* who has, or has had, the following conditions or problems:

** Include half brothers/half sisters*

CONDITIONS	MOTHER	FATHER	*BROTHERS	*SISTERS	UNCLES	AUNTS	GRANDPARENTS	CHILDREN
Alcoholism or Drug Abuse	○	○	○	○	○	○	○	○
Anorexia Nervosa	○	○	○	○	○	○	○	○
Anxiety	○	○	○	○	○	○	○	○
Arthritis/Rheumatism	○	○	○	○	○	○	○	○
Asthma, Hay Fever, or Allergies	○	○	○	○	○	○	○	○
Binge-Eating	○	○	○	○	○	○	○	○
Birth Defects	○	○	○	○	○	○	○	○
Bleeding Problems	○	○	○	○	○	○	○	○
Bulimia Nervosa	○	○	○	○	○	○	○	○
Cataracts	○	○	○	○	○	○	○	○
Cancer or Leukemia	○	○	○	○	○	○	○	○
Colitis	○	○	○	○	○	○	○	○
Deafness	○	○	○	○	○	○	○	○
Depression	○	○	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○	○	○
Drug Abuse	○	○	○	○	○	○	○	○
Epilepsy (seizures, fits)	○	○	○	○	○	○	○	○
Eczema	○	○	○	○	○	○	○	○
Gall Bladder Malfunction	○	○	○	○	○	○	○	○
Gambling	○	○	○	○	○	○	○	○
Glaucoma	○	○	○	○	○	○	○	○
Gout	○	○	○	○	○	○	○	○
Heart Attack	○	○	○	○	○	○	○	○
Heart Disease	○	○	○	○	○	○	○	○
Hyperlipidemia (excessive fat in blood)	○	○	○	○	○	○	○	○

CONDITIONS	MOTHER	FATHER	*BROTHERS	*SISTERS	UNCLES	AUNTS	GRANDPARENTS	CHILDREN
Hypertension (high blood pressure)	○	○	○	○	○	○	○	○
Jail or Prison	○	○	○	○	○	○	○	○
Kidney Disease	○	○	○	○	○	○	○	○
Liver Cirrhosis	○	○	○	○	○	○	○	○
Manic Depression (Bipolar)	○	○	○	○	○	○	○	○
Mental Retardation	○	○	○	○	○	○	○	○
Migraine or Sick Headaches	○	○	○	○	○	○	○	○
Nerve Diseases (Parkinson's, MS, etc.)	○	○	○	○	○	○	○	○
Obesity (overweight)	○	○	○	○	○	○	○	○
Psychiatric Hospitalization	○	○	○	○	○	○	○	○
Thyroid Disease/Goiter	○	○	○	○	○	○	○	○
Pernicious Anemia	○	○	○	○	○	○	○	○
Psychosis	○	○	○	○	○	○	○	○
Rheumatic Fever	○	○	○	○	○	○	○	○
Schizophrenia	○	○	○	○	○	○	○	○
Sickle Cell Disease	○	○	○	○	○	○	○	○
Stroke	○	○	○	○	○	○	○	○
Suicide Attempt	○	○	○	○	○	○	○	○
Suicide (completed)	○	○	○	○	○	○	○	○
Syphilis	○	○	○	○	○	○	○	○
Tuberculosis (TB)	○	○	○	○	○	○	○	○
Other Glandular Diseases	○	○	○	○	○	○	○	○
Ulcers	○	○	○	○	○	○	○	○
Yellow Jaundice	○	○	○	○	○	○	○	○
Other: _____	○	○	○	○	○	○	○	○

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2. If any of your *blood relatives* have not had ANY of the above conditions or problems, please indicate here:
   ○ Mother ○ Brothers ○ Uncles ○ Grandparents
   ○ Father ○ Sisters ○ Aunts ○ Children

N. MEDICATION HISTORY

1. What medications are you now taking?

MEDICATION NAME	DOSAGE	HOW LONG HAVE YOU BEEN TAKING THIS MEDICATION?

2. What drugs, medications, or shots are you allergic to?

MEDICATION/DRUG/SHOT NAME	REACTION

O. SOCIAL HISTORY

1. Highest level achieved in school (choose one):
   ○ 8th grade or less
   ○ Some high school
   ○ High school graduate
   ○ Trade or technical school
   ○ Some college
   ○ College graduate
   ○ Graduate study
   ○ Graduate degree
   ○ Post-graduate degree

   Specify highest degree attained:
   ○ M.D./D.O.
   ○ Ph.D./Psy.D./Ed.D.
   ○ Pharm.D.
   ○ M.A. or M.S.
   ○ B.A. or B.S.
   ○ B.S.N.
   ○ Other: _____

2. Are you now employed? ○ Yes ○ No If No, when were you last employed? _____

3. Current occupation or last work if now unemployed: _____

4. Were you ever in the armed services? ○ Yes ○ No
   Years of service (from when to when?) _____ Highest rank achieved _____

5. Have you ever been arrested? ○ Yes ○ No

Age(s) when arrested:	Reason(s) for arrest:	Did you spend time in jail?
_____	_____	_____
_____	_____	_____

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P. MEDICAL CHECKLIST

Fill in the circle of any of the following that you have experienced during the last four weeks. You should indicate items which are very noticeable to you and not those things which, even if present, are minor.

GENERAL:
- ○ Severe loss of appetite
- ○ Severe weakness
- ○ Fever
- ○ Chills
- ○ Heavy sweats
- ○ Heavy night sweats - bed linens wet
- ○ Fatigue
- ○ Sudden change in sleep

SKIN:
- ○ Itching
- ○ Easy bruising that represents a change in the way you normally bruise
- ○ Sores
- ○ Marked dryness
- ○ Hair fragile - comes out in comb
- ○ Hair has become fine and silky
- ○ Hair has become coarse and brittle

HEAD:
- ○ Struck on head - knocked out
- ○ Frequent dizziness that makes you stop your normal activity and lasts at least 5 minutes
- ○ Headaches that are different from those you normally have
- ○ Headaches that awaken you
- ○ Headaches with vomiting

EYES:
- ○ Pain in your eyes
- ○ Need new glasses
- ○ Seeing double
- ○ Loss of part of your vision
- ○ Seeing flashing lights or forms
- ○ Seeing halos around lights

EARS:
- ○ Pain in your ears
- ○ Ringing in your ears
- ○ Change in hearing
- ○ Room spins around you

NOSE:
- ○ Bleeding
- ○ Pain
- ○ Cannot breathe well
- ○ Unusual smells

MOUTH:
- ○ Toothache

Soreness or bleeding of:
- ○ Lips
- ○ Tongue
- ○ Gums

- ○ Unusual tastes
- ○ Hoarseness

NECK:
- ○ Pain
- ○ Cannot move well
- ○ Lumps
- ○ Difficulty swallowing
- ○ Pain on swallowing

NODES:
- ○ Swollen or tender lymph nodes (Kernals)

BREASTS:
- ○ Pain
- ○ New lumps
- ○ Discharge from nipples

LUNGS:
- ○ Pain in chest
- ○ Pain when you take a deep breath
- ○ New cough
- ○ Coughing up blood
- ○ Green, white, or yellow phlegm
- ○ Wheezing
- ○ Short of breath (sudden)
- ○ Wake up at night - can't catch breath
- ○ Unable to climb stairs

HEART:
- ○ Pain behind breastbone
- ○ Pain behind left nipple
- ○ Pain on left side of neck or jaw
- ○ Heart racing
- ○ Heart thumps and misses beats
- ○ Short of breath when walking
- ○ Need 2 or more pillows to sleep
- ○ Legs and ankles swelling (not with menstrual period)
- ○ Blue lips/fingers/toes when indoors and warm

GASTRO-INTESTINAL:
- ○ Have lost all desire to eat
- ○ Food makes me ill
- ○ Cannot swallow normally
- ○ Pain on swallowing
- ○ Food comes halfway up again
- ○ Sudden persistent heartburn
- ○ Pain or discomfort after eating
- ○ Bloating
- ○ Sharp, stabbing pains in side or shoulder after eating

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GENITO-URINARY:

- ○ Stabbing pain in back by lower ribs
- ○ Urinating much more frequently
- ○ Sudden awakening at night to urinate
- ○ Passing much more urine
- ○ Not making much urine
- ○ Unable to start to urinate
- ○ Must go to urinate quickly or afraid of losing urine
- ○ Pain on urination
- ○ Wetting yourself
- ○ Blood in urine
- ○ Pus in urine

NEUROLOGICAL:

- ○ Fainting
- ○ Fits
- ○ Weakness in arms or legs
- ○ Change in speech
- ○ Loss of coordination
- ○ Sudden periods or onset of confusion
- ○ Sudden changes in personality (suddenly not the same person)
- ○ Loss of ability to concentrate
- ○ Seeing things
- ○ Loss of touch
- ○ Tingling in arms or legs
- ○ Unable to chew properly
- ○ Memory loss
- ○ Tremulous or shaky

MALE:

- ○ Pain in testicles
- ○ Swelling of testicles
- ○ Swelling of scrotum

FEMALE:

- ○ Sudden change in periods
- ○ Between periods bleeding

LIST ANY OTHERS NOT MENTIONED ABOVE:

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