EARLY ONSET EATING DISORDER QUESTIONNAIRE
Australian Paediatric Surveillance Unit

Please ring Donna Rose on 02 9845 2200 if you have any problems with this questionnaire.

REPORTING CLINICIAN

1. APSU Dr Code/Name ☐☐☐☐ /…………………… 2. Month/Year of Report…..… /………

PATIENT

3. First 2 letters of first name ☐☐ 4. First 2 letters of surname ☐☐
5. Date of Birth: ☐☐ /☐☐/☐☐ 6. Sex ☐M ☐F
7. Postal code ☐☐☐☐
8. Date of diagnosis ☐☐ /☐☐/☐☐ 9. Date questionnaire completed ☐☐ /☐☐/☐☐

If this patient is primarily cared for by another physician who you believe will report the case, please complete the questionnaire details above this line and return to APSU. If no other report is received for this child we will contact you for information requested in the remainder of the questionnaire.

Please keep the patient's name and other details in your records.

Instructions: Please answer each question by placing a tick in the appropriate box or writing your response in the space provided. DK=Don't Know

CLINICAL FEATURES
Please indicate symptoms or signs present at the time of presentation. Please respond to each item.

10. food avoidance ☐Yes ☐No ☐DK
11. excessive exercising ☐Yes ☐No ☐DK
12. self induced vomiting ☐Yes ☐No ☐DK
13. fear of weight gain/fatness ☐Yes ☐No ☐DK
14. perception that body shape/size is larger than it is ☐Yes ☐No ☐DK
15. preoccupation with body weight ☐Yes ☐No ☐DK
16. preoccupation with food/ food intake ☐Yes ☐No ☐DK
17. laxative abuse ☐Yes ☐No ☐DK
18. diuretic abuse ☐Yes ☐No ☐DK
19. somatic complaints eg. abdominal pain without specific cause ☐Yes ☐No ☐DK
20. denial of severity of illness ☐Yes ☐No ☐DK
21. Is weight loss/failure to gain weight due to an organic cause ☐Yes ☐No ☐DK
22. Has the child reached menarche? ☐Yes ☐No ☐DK ☐Not applicable
23. IF YES to 22, is there now secondary amenorrhoea? ☐Yes ☐No ☐DK ☐Not applicable
24. Current weight …………………kg …..………..centile
25. Current height……………….…cm …………….centile
26. Change in weight over previous 6 months
    ☐ no change
    ☐ decreased (if known, specify decrease in kg ….….)
    ☐ increased (if known, specify increase in kg ….….)
    ☐ DK
27. Change in height over previous 6 months
    ☐ no change
    ☐ increased (if known, specify increase in cm ….….)
    ☐ DK
28. Maximum weight ever recorded ………………kg ……………..centile ☐DK
29. Date when maximum weight was recorded (year & month)……………………………
30. Pubertal Status: *Tanner Stage*
    a. Breast development: ☐ Stage 1 ☐Stage 2 ☐ Stage 3 ☐ Stage 4 ☐ Stage 5 ☐ DK ☐ Not applicable
    b. Pubic Hair: ☐ Stage 1 ☐Stage 2 ☐ Stage 3 ☐ Stage 4 ☐ Stage 5 ☐ DK
31. What was the duration of symptoms prior to diagnosis?……………...weeks or ……………months ☐DK

EXAMINATION FINDINGS

Please indicate if any of the following were detected.

32. Temperature <35.5 C ☐ Yes ☐ No ☐ DK
33. Hypotension (systolic BP <80) ☐ Yes ☐ No ☐ DK
34. Bradycardia (<50 beats/min) ☐ Yes ☐ No ☐ DK IF YES, lowest recorded rate……..……

PSYCHIATRIC ILLNESS

Did the child have a concurrent psychiatric illness?

35. Depression ☐ Yes ☐ No ☐ DK
36. Obsessive compulsive disorder ☐ Yes ☐ No ☐ DK
37. Anxiety ☐ Yes ☐ No ☐ DK
38. Any other psychiatric illness (please specify)…………………………………….…………..…………
    ……
39. Is there a family history of psychiatric illness (including anorexia nervosa)? ☐ Yes ☐ No ☐ DK
40. IF YES to 39, please give diagnosis and relationship to child……….………………………………….
    ……

MANAGEMENT

41. Was the child admitted to hospital? ☐ Yes ☐ No ☐ DK
42. IF YES to 41, please indicate the type of hospital to which the child was admitted:
    a. Metropolitan general hospital ☐ Yes ☐ No ☐ DK
    b. Rural community hospital ☐ Yes ☐ No ☐ DK
    c. Paediatric teaching hospital ☐ Yes ☐ No ☐ DK
    d. General psychiatric hospital ☐ Yes ☐ No ☐ DK
    e. Child & Adolescent Psychiatric Unit ☐ Yes ☐ No ☐ DK
43. If the child has already been discharged, what was the total duration of hospital admission?………..days
44. If the child has not been discharged, what is the total duration of admission to date? …….….…….days
45. Did the child receive naso-gastric tube feeding? ☐ Yes ☐ No ☐ DK
46. Were psychotropic medications prescribed for concurrent psychiatric illness? ☐ Yes ☐ No ☐ DK
47. IF YES to 46, specify psychotropic medication(s) …………………………………………………………
48. At the time of your last contact with the family was the child alive? ☐ Yes ☐ No ☐ DK
49. IF YES to 48, in your opinion was the patient's condition ☐ improved ☐ unchanged ☐ worse ☐ DK

PROFESSIONALS INVOLVED IN CARE

Please indicate which of the following health professionals have been required in the patient's care.

50. Paediatrician ☐ Yes ☐ No ☐ DK
51. Psychiatrist ☐ Yes ☐ No ☐ DK
52. Dietitian ☐ Yes ☐ No ☐ DK
53. Psychologist ☐ Yes ☐ No ☐ DK
54. Specialist eating disorder unit ☐ Yes ☐ No ☐ DK
55. Other (please specify). ……………………………………………………………………………………..

HISTORY

56. Was this child born prematurely ☐ Yes ☐ No ☐ DK IF YES specify gestation ……../40 weeks
57. Does this child have a history of significant feeding difficulties in early life ☐ Yes ☐ No ☐ DK IF YES please specify ……………………………………………………………………………………………
    …….

Please return this questionnaire in the addressed reply-paid envelope.

Thank you for your help with this project.

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