



Screening for Eating Disorders by Primary Care Physicians

Compiled and Written by Margo Maine, PhD

As a primary care provider, you could be the first person to recognize and offer assistance regarding a patient's eating and weight concerns. Please incorporate these questions into your patient interviews. Although a patient may not disclose enough information immediately, your sustained interest and concern may eventually allow your patient to admit their problems and accept your help.

Ask About:

- Recent weight fluctuations
- History of weight fluctuations
- Report of meals eaten on previous day
- Periods of bingeing or feeling a lack of control over food intake
- Comfort with current weight/shape
- Menstrual history
- Family history of eating disorders, depression, chemical dependence
- Desired weight
- Actions taken to maintain, control, or alter weight
- Any attempts to lose weight through:
 - Laxatives
 - Diuretics
 - Diet pills
 - Vomiting
 - Enemas
 - Exercise
 - Exercise habits (how much? how often? why?)
 - Other supplements (from health food stores)



Addressing Eating Disorders as a Physicians

A “Twelve Step” Program

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1. Admit the problem. Sizeism, weightism, “ideal thinness” and unattainable standards of beauty exist in:
 - Our culture
 - Your patients
 - You (?)
2. Ask questions about weight, menstrual, and dieting history:
 - A patient’s usual weight
 - Weight and menstrual fluctuations
 - Dieting
 - Other behaviors being used to change weight
3. Convey the importance of adequate nutritional intake, especially:
 - Calcium
 - Protein
 - Adequate fat
 - Balance (the food pyramid)
4. Do not overemphasize weight as an indicator of general health.
5. Understand and explain to patients the set point theory.
6. Be concerned about amenorrhea
 - Bone density
 - Fertility
7. Educate patients and staff about the dangers of dieting
 - Sets up a “binge”
 - Decreases BMR
 - Makes it easier to store fat
 - Impairs physical, psychological, and emotional functioning
8. Maintain a weight sensitive office.
 - No jokes about eating disorders
 - Privacy when weighing patients/ no weighing in public location
 - Respect client’s feelings
9. Provide educational materials about appropriate nutrition and eating disorders.
10. Bring up your concerns directly to patient.
 - Confront or Carefront? Present concerns in a sensitive and caring way.
11. Know the local and national resources for treatment.
 - For information and treatment referrals, contact NEDA at 800-931-2237 or NationalEatingDisorders.org.
12. Respect the power of illness.
 - Establish an appropriate treatment plan
 - Collaborate with mental health specialists
 - *Hang in there – your support and concern are important.*



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www.NationalEatingDisorders.org · Information and Referral Helpline: 800.931.2237

TABLE 1 -- Recommended Laboratory Tests

Standard

- Complete Blood Count (CBC) with differential
- Urinalysis
- Complete Metabolic Profile: Sodium, Chloride, Potassium, Glucose, Blood Urea Nitrogen, Creatinine, Total Protein, Albumin, Globulin, Calcium, Carbon Dioxide, AST, Alkaline Phosphates, Total Bilirubin
- Serum magnesium
- Thyroid Screen (T3, T4, TSH)
- Electrocardiogram (ECG)

Special Circumstances

15% or more below ideal body weight (IBW)

- Chest X-Ray
- Complement 3 (C3)
- 24 Creatinine Clearance
- Uric Acid

20% or more below IBW or any neurological sign

- Brain Scan

20% or more below IBW or sign of mitral valve prolapse

- Echocardiogram

30% or more below IBW

- Skin Testing for Immune Functioning

Weight loss 15% or more below IBW lasting 6 months or longer at any time during course of eating disorder

- Dual Energy X-Ray Absorptiometry (DEXA) to assess bone mineral density
- Estadiol Level (or testosterone in males)

**Also refer to the American Psychiatric Association (APA) & DSM IV-R for more detailed information.
<http://www.psychiatryonline.com/popup.aspx?aID=139471>

TABLE 2 -- Criteria for Level of Care

Inpatient

Medically Unstable

- Unstable or depressed vital signs
- Laboratory findings presenting acute risk
- Complications due to coexisting medical problems such as diabetes mellitus

Psychiatrically Unstable

- Symptoms worsening at rapid rate
- Suicidal and unable to contract for safety

Residential

- Medically stable so does not require intensive medical interventions
- Psychiatrically impaired and unable to respond to partial hospital or outpatient treatment

Partial Hospital

Medically stable

- Eating disorder may impair functioning but not causing immediate acute risk
- Needs daily assessment of physiological and mental status

Psychiatrically stable

- Unable to function in normal social, educational, or vocational situations but not suicidal
- Daily bingeing, purging, severely restricted intake, or other pathogenic weight control techniques

Intensive Outpatient/Outpatient

Medically stable

- No longer needs daily medical monitoring

Psychiatrically stable

- Symptoms in sufficient control to be able to function in normal social, educational, or vocational situations and continue to make progress in recovery

