

NEW PEDIATRIC HEALTH FORM

Name: (First) _____ (Last) _____ (MI) _____
Date of Birth: ____/____/____ Date of Visit: ____/____/____
Phone: (Home/Cell) _____ (Work) _____
Sex: Male Female Transgender (F to M) Transgender (M to F) Gender queer
 Choose not to disclose Other gender category not listed _____

Referred By: _____

How does weight affect your child's life and health?

Weight History

When did you first notice that your child was gaining weight?

- Infancy Childhood Adolescence Pregnancy

Did your child ever gain more than 20 pounds in less than 3 months? Yes No

If so, when? _____

How much did your child weigh: One year ago? _____ Five years ago? _____ Ten years ago? _____

What was your child's maximum weight? _____

Life events associated with weight gain (check all that apply):

- | | | | |
|--|---|------------------------------------|---------------------------------|
| <input type="checkbox"/> Marriage of a parent | <input type="checkbox"/> Divorce of a parent | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Abuse |
| <input type="checkbox"/> Illness | <input type="checkbox"/> Death of a parent/relative | <input type="checkbox"/> Travel | <input type="checkbox"/> Injury |
| <input type="checkbox"/> Job change in household | <input type="checkbox"/> Quitting smoking | <input type="checkbox"/> Alcohol | |
| <input type="checkbox"/> Change of school | <input type="checkbox"/> Other chronic stress | | |

Medication (please list): _____

What were your child's perceived weight change triggers: _____

What changes have you already tried to make? (check all that apply)

- Commercial weight loss program Specific Diet (Keto, Atkins, Low-carb, Mediterranean diet, Paleo)
 Seen a dietician Other: _____

What are your greatest challenges with your child's weight?

Medication History:

Has your child ever taken medication to lose weight? (check all that apply)

- | | | | |
|---|----------------------------------|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Phentermine (Adipex) | <input type="checkbox"/> Meridia | <input type="checkbox"/> Xenecal/Alli | <input type="checkbox"/> Metformin |
| <input type="checkbox"/> Contrave | <input type="checkbox"/> Topamax | <input type="checkbox"/> Saxenda | <input type="checkbox"/> Victoza |
| <input type="checkbox"/> Bupropion (Wellbutrin) | <input type="checkbox"/> Ozempic | <input type="checkbox"/> Trulicity | <input type="checkbox"/> Qsymia |

Other (including supplements): _____

What worked? _____

What didn't work? _____

Why or why not? _____

What worked? _____
What didn't work? _____
Why or why not? _____

Medications (list all current medications, including over-the-counter medications, supplements, and herbs):

Nutritional History

How often does your child eat breakfast? _____ days per week at _____ : _____ a.m.
Number of times your child eats per day: _____ What beverages do they drink? _____
Do they get up at night to eat? ___ Yes ___ No
If so, how often? _____ times
List any food intolerances/restrictions: _____

Food triggers (check all that apply):

- Stress Boredom Anger Insomnia Seeking reward
 Parties Eating out None Other: _____

Food cravings:

- Sugar Chocolate Starches Salty Fast food
 High fat Large portions None

Favorite foods: _____

Behavior

Does your child display "out of control" behavior towards eating? (eating too much, "hungry" all the time, sneaking food) Yes No

Does your child need help with establishing boundaries for food/eating? Yes No
Do you think your child eats due to sadness, boredom and/or loneliness? Yes No

Has your child or your family experienced recent trauma or stress that you feel may be contributing to current health concerns? Yes No

Describe: _____

Has there ever been a diagnosis of an eating disorder? Yes No
If yes, which one? _____

Food insecurity

Within the past 12 months, we were worried whether our food would run out before we got money to buy more? Yes No

Within the past 12 months, the food we bought just didn't last and we didn't have money to get more? Yes No

Medical History

Past medical history (check all that apply):

- Gallbladder stones Indigestion/reflux Thyroid disease Diabetes

Gynecologic History (Female)

Menstrual periods are:

Not Started Regular Irregular Heavy Normal Light Absent N/A

Age menstrual periods began: _____ N/A

History of Pregnancy: Yes No N/A

System Review (Check all that apply)

General:

Recent weight loss Recent weight gain Increased appetite Decreased appetite

Respiratory:

Cough Snoring Shortness of breath

Cardiovascular:

Chest pain Fainting Swelling ankles/extremities Palpitations

Gastrointestinal:

Abdominal pain Bloating Constipation Diarrhea
 Dysphagia/difficulty swallowing Food intolerance Indigestion Heartburn
 Nausea/vomiting Gas and bloating Blood in stools

Genitourinary:

Urinary frequency/urgency Nighttime urination

Musculoskeletal:

Back pain (upper) Back pain (lower) Muscle aches/pain Joint pain

Integumentary:

Acne Rash Skin breakdown

Neurological:

Dizziness Headaches Weakness/low energy Seizures
 Fainting/Syncopal episodes

Psychiatric:

Anxiety Depression Insomnia Hyperactivity
 Inability to concentrate Nervousness Mood changes Inattention

Endocrine:

Excessive thirst Cold intolerance Excessive sweating Hair changes
 Heat intolerance

Immunologic:

Fatigue/tiredness Bruising

Comments: _____

Important Update to Our Appointment Policy

At Weight In Gold, we value the time and commitment of all our patients. To ensure we can provide the best care for everyone, we kindly ask for at least 24 hours' notice if you need to cancel or reschedule your appointment.

This allows us to offer the available time slot to someone else who may need it.

Please Note:

If no notice is given within 24 hours of your appointment, a no-show fee will be applied to your account.

We understand that unexpected situations arise and will always do our best to accommodate you. If you have any concerns or need assistance, don't hesitate to reach out to us.

Thank you for helping us maintain a smooth and efficient care experience for all!

Acknowledgment of 24-Hour Cancellation Policy

I have read and understand the 24-hour cancellation policy and agree to its terms.

Patient Signature: _____

Date: _____