Weight In Gold™

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):
☐ Marriage of a parent ☐ Divorce of a parent ☐ Pregnancy ☐ Abuse
☐ Illness ☐ Death of a parent/relative ☐ Travel ☐ Injury
☐ Job change in household ☐ Quitting smoking ☐ Alcohol
☐ Change of school ☐ 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)
☐ Phentermine (Adipex) ☐ Meridia ☐ Xenecal/Alli ☐ Metformin
☐ Contrave ☐ Topamax ☐ Saxenda ☐ Victoza
☐ Bupropion (Wellbutrin) ☐ Ozempic ☐Trulicity ☐ 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

☐ High blood pressure ☐ High cholesterol ☐ Celiac disease ☐ Anxiety
☐ High triglycerides ☐ Pancreatitis ☐ Depression ☐ Bullying
☐ ADHD ☐ Bipolar ☐ Polycystic ovarian syndrome
☐ Arthritis ☐ Kidney Disease ☐ None
☐ Other: _____

Past surgical history (check all that apply):
☐ Gastric bypass ☐ Gastric banding ☐ Gastric sleeve ☐ Gallbladder
☐ Other: _____

Allergies:
(Medications)_____
(Food)_____

Sleep History

How many hours does your child sleep per night? _____
Does your child feel rested in the morning? ☐ Yes ☐ No
Please indicate if your child has any of the following:
☐ Snoring ☐ Pauses in breathing ☐ Waking with dry throat
☐ Daytime sleepiness ☐ Sleep apnea/disordered eating ☐ Nocturnal enuresis
☐ Night eating

Physical Activity History

Describe the type of physical activity your child engages in:
_____
Duration: _____ hours _____ minutes Number of times per week: _____
Does anything limit your child from being physically active? _____
_____

Social History

Smoking: ☐ N/A ☐ Never ☐ Current smoker (___packs/day)
☐ Past smoker (quit _____ years ago) ☐ Vaping

Alcohol: ☐ N/A ☐ Never ☐ Occasional ☐ Regularly (_____ drinks per day)
Drugs: ☐ N/A ☐ Never ☐ Current ☐ Past ☐ Type of drugs: _____
Marijuana: ☐ N/A ☐ Never ☐ Current user (_____ times/day)

Family History

Obesity (check all that apply): ☐ Mother ☐ Father ☐ Sister ☐ Brother
☐ Grandmother ☐ Grandfather
Diabetes (check all that apply): ☐ Mother ☐ Father ☐ Sister ☐ Brother
☐ Grandmother ☐ Grandfather

Other (check all that apply):
☐ High blood pressure ☐ Heart disease ☐ High cholesterol ☐ High triglycerides ☐ Stroke
☐ Thyroid problems ☐ Anxiety ☐ Depression ☐ Bipolar disorder ☐ Alcoholism
☐ Liver disease ☐ Sleep disorder ☐ Pancreatitis ☐ Asthma ☐ ADHD
☐ Kidney Disease ☐ Cancer (type/s): _____ ☐ Other: _____

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: _____
_____
_____
_____