Pediatric Weight Management *Initial* Visit

Regular MD:

Last Name, First Name

Medical Number

IMPRINT AREA

Age: __________Yrs

Height:____________in / cm

Smoker In Home? ☐ Yes ☐ No

Weight?____________# / Kg

BP:______ __/______

Current Smoker? ☐ Yes ☐ No

HR:_______________# / min

BMI:________/________%

Patient Concerns:____

Date:___________

Allergies: ☐ None

Accompanied By: ☐ Mom ☐ Dad ☐ Other:

Phone: ____

HISTORY

Chief Complaint/History of Present Illness________________________________

☐ **Questions or Concerns**________________________________

☐ **Self Esteem – Self Image**________________________________

☐ **Perception of Weight & Health**________________________________

☐ **Current Health Habits**________________________________

Physical Activity **(active play, sports)**________________________________

Sedentary Time **(TV, video games)**________________________________

Nutrition________________________________

(sodas/juice/fast food, fruits/veg, dairy, portion sizes)

Eating Habits ________________________________

(meal skipping, family meals, binging-purging)

☐ **Successes & Barriers**________________________________

☐ **Areas Chosen by Family to Work On**________________________________

☐ **Readiness to Change** **(child vs parent)**________________________________

☐ **Health Goals**________________________________

☐ **Rewards**________________________________

REVIEW OF SYSTEMS

No Problem		Problem	
	Constitutional		
☐	*Depression*	☐	__________
☐	*Fatigue / Lethargy*	☐	__________
☐	Fever	☐	__________
	HEENT		
☐	Ear Pain	☐	__________
☐	Runny Nose	☐	__________
☐	*Snoring*	☐	__________
☐	Sore throat	☐	__________
	Respiratory		
☐	Cough	☐	__________
☐	*Difficulty Breathing (noc)*	☐	__________
☐	*Wheezing / Stridor*	☐	__________
	Cardiovascular		
☐	Chest Pain	☐	__________
☐	**All other systems negative**		

No Problem		Problem	
	Gastrointestinal		
☐	*Abdominal Pain*	☐	__________
☐	*Vomiting*	☐	__________
	Skin		
☐	*Striae*	☐	__________
	Neurologic		
☐	*Developmental Delay*	☐	__________
☐	*Headache*	☐	__________
	Genitourinary		
☐	*Menarche*	☐	__________
☐	*Oligo / Amenorrhea*	☐	L.M.P.:__________
	Musculoskeletal		
☐	*Limp*	☐	__________
	Knee / Hip Pain	☐	__________
	Allergy		
☐	Medication Allergy	☐	__________

PAST-FAMILY-SOCIAL HISTORY

☐ Tobacco Exposure Noted Above__________________

☐ Immunizations Reviews__________________

☐ Medical Record Reviewed__________________

☐ Family History__________________

☐ *Obesity/Overweight*__________________

☐ *Type 2 Diabetes*__________________

☐ *Hypertension*__________________

☐ *Cardiovascular Disease*__________________

☐ *Depression*__________________

Interpreter Used: ☐ No ☐ Yes - Language:__________________

MEDICATIONS

☐ None

☐ See History

☐ See Chronic Med List

☐ Acetaminophen

☐ Ibuprofen

☐ Metformin

☐ Other__________________

XXX

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PHYSICAL EXAM

NL — NL=Normal, AB=Abnormal, Blank=Not Examined — AB — **Abnormal Findings:**

- ☐ 1 Constitutional (alert, not toxic, not dysmorphic)..... ☐
- ☐ 2 Eyes (no conjunctival infection, no papilledema)..... ☐
- ☐ 3 ENT (no ext ear pain, TM's clear, nasal mucosa nl, teeth/gums nl., oral-pharynx nl, mucous memb moist)..... ☐
- ☐ 4 Neck (supple, no adenopathy/masses, thyroid nl)..... ☐
- ☐ 5 Resp (clear by auscultation, no retractions)..... ☐
- ☐ 6 Heart (regular rhythm, no murmur)..... ☐
- ☐ 7 Abd (nontender, no mas/organomegaly, bowel sounds nl)..... ☐
- ☐ 8 Skin (no striae, no hirsutism, no acanthosis nigricans)..... ☐
- ☐ 9 Extr (no cyanosis, pulses & perfusion nl, no edema)..... ☐
- ☐ 10 Musc (nl gait, full ROM without pain, no tibial bowing)..... ☐
- 11 GU
  - ☐ Ext Gen Vagina/Vulva (no lesions/discharge)..... ☐
  - ☐ Penis/Scrotum (no lesions/dischc, testes nl)..... ☐
  - ☐ Tanner Stage (genital/breast): I II III IV V
  - ☐ Tanner Stage (pubic hair): I II III IV V
- ☐ 12 Neuro (DTR 2+, CN 2-12 nl)..... ☐
- ☐ 13 Psych (normal affect and memory)..... ☐

ASSESSMENT

☐	**Overweight**	(BMI>=95% for Age)
☐	**At Risk for Overweight**	(BMI 85-95% for Age)
☐	**Normal Weight**	(BMI 5-84% for Age)

Weight Change Since Last Visit:

Child Readiness to Change	Parent Readiness to Change
☐ High	☐ High
☐ Medium	☐ Medium
☐ Low	☐ Low

Areas of Improvement
- ☐ Activity
- ☐ Nutrition
- ☐ Self-Esteem
- ☐ Other:

MEDICATIONS

MEDICAL DATA

- ☐ CBC
- ☐ UA
- ☐ Fasting Cholesterol/Lipid Panel
- ☐ Fasting Blood Glucose
- ☐ Fasting Insulin
- ☐ Random Glucose
- ☐ HgbA1C
- ☐ TSH/Free T4
- ☐ SGPT/SGO/Billirubin
- ☐ X Ray:____________________
- ☐ Old Records Reviewed

IMMUNIZATIONS

☐ DTAP	☐ Hep B	☐ Con-Pneumo	☐ V-Z	☐ Td
☐ IPV	☐ HIB	☐ MMR	☐ Hep A	☐ Influenza

PLAN

COUNSELING – INFORMATION

- ☐ Environmental Tobacco Smoke
- ☐ Smoking cessation / Advised to Quit

☐ **Counseling**:
- ☐ Activity/Exercise
- ☐ Nutrition/Eating Habits
- ☐ Self-Esteem
- ☐ Body Acceptance
- ☐ Other:

☐ **Written Information**:
- ☐ Tip Sheet
- ☐ Health Goals Spreadsheet
- ☐ Other:

☐ **Referral To**:
- ☐ Dietician
- ☐ Weight Management Program
- ☐ Mental Health
- ☐ Other:

RTC: ☐ PRN ☐________wk / month

Patient/Family Goals

5
2
1
0

Sign Here… **Date Here…** / /

MD/DO/NP

XXX