Mt. Washington Pediatric Hospital

Weigh Smart® Program

New Patient Information Form

1708 West Rogers Avenue ♦ Baltimore, Maryland 21209-4596
*(410) 367-2222 ♦ **FAX:** (410) 578-2654*
weighsmart@mwph.org

Place Label Here or Insert

_____ _____
Last Name, First Name

Med Rec #_____ and

Date of Birth_____

PLEASE HAVE YOUR CHILD'S PRIMARY CARE PHYSICIAN SEND GROWTH CHARTS, LAB WORK RESULTS, AND VISIT NOTES TO US VIA FAX OR MAIL.

Today's Date: _____

Name of person completing the form: _____

What is your relationship to the child: _____

Do you have custody of child: Yes No

If not, who does: _____

If applicable, what type of custody (please circle): Joint Sole Other

Child's Name: _____ Sex:__M __F

Date of Birth: _____Age:_____ Current Weight: _____Ht: _____

Patient Ethnicity: (for informational purposes and is optional) **PLEASE CIRCLE**

0-Caucasian 1-African American 2-Hispanic 3-Asian 4-Other_____

Home address: _____

Include City, State, & Zip Code _____

Parent/Guardian (1) Name: _____Relationship to child:_____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

E-mail Address: _____

Parent/Guardian (2) Name: _____Relationship to child:_____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

E-mail Address: _____

Address (if different)_____

City, State, & Zip Code _____

Referring Physician: _____ Phone: _____

Primary Care Physician: (if different)_____

Why are you interested in our program: _____

BIRTH HISTORY:

Weight:_____Length:_____Full Term: **Yes** **No**

Which hospital?_____

If premature, at what week was child born:_____

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Please Describe:

Problems during pregnancy: Yes No _____

Problems during delivery: Yes No _____

Problems in the first month: Yes No _____

PAST MEDICAL HISTORY:

What childhood illnesses has your child been treated for: _____

Has your child ever been hospitalized: No Yes, please list: _____

Has your child ever had surgery: No Yes, please list: _____

Has your child had any accidents: No Yes, please list: _____

Has your child had any special medical treatments for a medical condition: No Yes

If yes, please list: _____

EATING STYLE:

Does your child: (Please circle which applies)

eat large meals? Y/ N eat quickly? Y/N likes to nibble? Y/N

eats school breakfast? Y/N eats school lunch? Y/N

eats at before/after school program? Y/N

Skips meals: Y/N If yes, which meal(s)? (**Please Circle):** Breakfast Lunch Dinner

Number of fast food meals/week: _____ Which restaurant(s): _____

Number of meals eaten outside the home/ week: _____ Where: _____

Have you previously tried diets/programs to help any of your children lose weight: Yes No

If yes, which one(s): _____

ALLERGIES: (Please circle)

Allergy to Food: No Yes, please list: _____

Allergy to Medicine: No Yes, please list: _____

Lactose Intolerant: No Yes, please list foods you avoid: _____

Allergy to Latex: No Yes

Immunizations up to date Yes No, please describe_____

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FAMILY HISTORY:

Biological Parents:

Mother: Age: _____ Ht: _____Current Wt: _____ Most you've weighed:_____

Father: Age: _____ Ht: _____Current Wt: _____ Most you've weighed:_____

Siblings:	Age	Ht.	Wt.	Male/Female
Full – Half – Step	_____	_____	_____	M F
Full – Half – Step	_____	_____	_____	M F
Full – Half – Step	_____	_____	_____	M F
Full – Half – Step	_____	_____	_____	M F
Full – Half – Step	_____	_____	_____	M F
Full – Half – Step	_____	_____	_____	M F

Circle if there is a family history of: (note: includes extended family- grandparents, aunts, uncles, cousins…)

Diabetes	Hypertension	Personality Disorder	Thyroid Problems
Peptic Ulcer	Heart Disease	Schizophrenia	Reflux
Gallbladder	Kidney disease	Weight loss surgery	Liver Disease
Pancreatitis	Obesity	Eating Disorders	
Arthritis	Cancer	Seizure	
Stroke	ADHD	Depression	Other:_____
Infertility	Anxiety	Learning Problems	
Constipation	Mental Retardation	Food allergies	

SOCIAL HISTORY:

Who lives at home with your child: **CIRCLE ALL THAT APPLY**

Mother Father Step-parent Sibling(s) Grandparent(s) Other

Does your child live between two households? Yes No

What school and grade is your child in: _____

Does your child have either an IEP: Yes No or 504 plan: Yes No

If yes, please detail: _____

Physical activity at home: _____ Parents involved: Yes No

Physical Education at school: Yes No, How often: _____

Hours of after-school organized sports a week: _____

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Mother's highest level of education: **PLEASE CIRCLE**
0-High School 1-GED 2-Some College 3-College Degree 4-Graduate Degree
5- Elementary School

Mother's Occupation: _____ and number of hours worked/week: _____

Father's highest level of education: **PLEASE CIRCLE**
0-High School 1-GED 2-Some College 3-College Degree 4-Graduate Degree
5- Elementary School

Father's Occupation:_____ and number of hours worked/week: _____

Primary caregiver's work schedule: **CIRCLE ALL THAT APPLY**
0-Weekends 1-Weekdays 2-Days 3-Nights

Any significant changes in the family in the past 6 months: _____

Is there anyone involved in the child's life that may not be supportive of weight loss: Yes No

If yes, what is their relationship to your child: _____

MEDICATIONS: Please list all medications within the last 3 months (include vitamins, health food remedies, etc.)_____

_____

REVIEW OF SYSTEMS:

Does your child have any of these symptoms? (Circle any that apply)

Allergy (please list)
_____
Bleeding tendency
Recurrent headaches
Morning headaches
Trouble breathing
Shortness of breath
Heaving breathing
Asthma
Snoring if yes:
Sleep study done? Y/N
If yes, when/where):
_____

Has dreams at night
Mouth open during the day
Heartburn
Abdominal pain
Constipation
Diarrhea
Bedwetting/urinary problems
Joint problems
Other pain_____
Tired in the morning

Sleepy in school
Easily distracted
Difficulty organizing
Interrupts conversations
Wears glasses
Trouble following directions
Problems with balance or coordination
Irregular periods

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Has your child ever been treated for the following conditions (please circle any that apply):

	Comments
ADHD	_____
ODD	_____
Anxiety	_____
Depression	_____
Mental Health Conditions	please describe:_____
Legal issues	_____
Behavior issues	please describe:_____

Does your child currently see a mental health professional? (school counselor, social worker, psychologist, psychiatrist, etc) Yes No

Please provide their name and reasons for therapy:_____

Has your child seen a mental health professional in the past?
(school counselor, social worker, psychologist, psychiatrist, etc) Yes No

Is the child currently on or has been on any psychiatric medications? Yes No
If so, please list_____

FOOD INTAKE RECORD: Write down everything your child eats (include sauces and drinks) **for one day**. To ensure accurate results, record the information whenever anything is eaten and/or any beverages.

TIME OF DAY	FOOD/DRINK EATEN	AMOUNT	LOCATION OF MEAL

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Your child's insurance information:

Insurance company (ex Aetna, Priority Partners, Maryland Physician Care etc):_____

Policy number/ Subscriber number/Member ID/Medicaid number

Policy holder's name and date of birth (if commercial insurance):

_____

Please return this completed form to MWPH and we will reach out to schedule the new patient appointment.

Email to: weighsmart@mwph.org

Mail to: Weigh Smart® Program
1708 West Rogers Ave
Baltimore, MD 21209

Fax to us: 410-578-2654

If you choose to email this form to Mt. Washington Pediatric Hospital using unencrypted email, please sign below that you understand your child's personal and health information may be at risk if sent using an unsecured email system.

_____ _____

Signature, parent/guardian Date

