



# Mt. Washington Pediatric Hospital

## Weigh Smart® Program

### New Patient Information Form

1708 West Rogers Avenue ♦ Baltimore, Maryland 21209-4596  
(410) 578-5342 ♦ FAX: (410)578-2654

Place Label Here or	
_____	_____
<i>Last Name,</i>	<i>First Name</i>
Med Rec # _____ or	
Date of Birth _____	

**PLEASE OBTAIN A COPY OF YOUR CHILD'S GROWTH CHART FROM YOUR PRIMARY CARE PHYSICIAN AND ATTACH TO THIS FORM. RETURN ALL FORMS TO THE ABOVE ADDRESS**

Today's Date: 3/14/07

Name of person completing the form and relationship to child: Bill Lopez, Father

Do you have custody of child:  Yes No If not, who does: \_\_\_\_\_

Patient Name: Josh Lopez

Date of Birth: 2/28/1997 Age: 10 Current Weight: 146 Ht: 4'8"

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

0-Caucasian

3-Asian

1-African American

4-Other \_\_\_\_\_

2-Hispanic

Address: 123 W Main St Baltimore, MD, 21210

Telephone: Home: 410-141-0911

E-mail Address: Bill.Lopez@cia.gov

Parent's name: Bill Lopez Work Telephone: 433-123-1234

Referring Physician: Doctor Doc Phone: 410-432-2345

Why are you interested in our program: To help my child lose weight and feel better

#### **BIRTH HISTORY:**

Weight: 8 lb Length: 20 ½ inches Full Term:  Yes No Premature: Yes  No

Please describe:

Problems during pregnancy: Yes  No

Problems during delivery:  Yes  No

had c-section b/c heart rate was dropping

Problems in the first month: Yes  No

#### **FEEDING HISTORY:**

Breast fed:  Yes No

If yes, how long: 4 months and if yes please circle one:  Pumped or  Nursed

What infant formulas were used: soy formula

At what age were rice cereal and baby foods introduced: 5 months

Place Label Here or
<div style="display: flex; justify-content: space-between; border-bottom: 1px solid black; margin-bottom: 5px;"> <span style="width: 45%;"><i>Last Name,</i></span> <span style="width: 45%;"><i>First Name</i></span> </div> <div style="display: flex; justify-content: space-between; border-bottom: 1px solid black; margin-bottom: 5px;"> <span style="width: 70%;"><i>Med Rec #</i></span> <span style="width: 25%;"><i>Or</i></span> </div> <div style="display: flex; justify-content: space-between; border-bottom: 1px solid black;"> <span style="width: 80%;"><i>Date of Birth</i></span> </div>

What foods do you avoid giving to your child: **none** \_\_\_\_\_

Is there a history of feeding disorders: Yes  No

If yes, what kind: \_\_\_\_\_

**EATING STYLE:**

Does your child eat large meals:  Yes  No

Likes to nibble:  Yes  No

Skips meal: Yes  No (if yes, which meal or meals, please circle):

**Breakfast      Lunch      Dinner**

Who grocery shops: **PLEASE CIRCLE ALL THAT APPLY**

- |   |                    |
|---|--------------------|
| <input checked="" type="radio"/> 0-Mother | 1-Father           |
| 2-Both Parents                            | 3-Grandparent      |
| 4-Child                                   | 5-Child and Parent |
| 6-Child and Grandparent                   |                    |

Who prepares the meals: **PLEASE CIRCLE**

- |                         |  |
|-------------------------|--|
| 0-Mother                | 1-Father                                       |
| 2-Both Parents          | <input checked="" type="radio"/> 3-Grandparent |
| 4-Child                 | 5-Child and Parent                             |
| 6-Child and Grandparent |  |

Number of fast food meals/week: **2** \_\_\_\_\_ Which restaurant(s): **Taco Bell** \_\_\_\_\_

How many meals eaten outside the home/ week: **4** \_\_\_\_\_ Where: **Grandma's house and restaurants** \_\_\_\_\_

Favorite foods: **Lasagna, Burgers** \_\_\_\_\_

Favorite drinks: **Apple Juice** \_\_\_\_\_

Eats at the table with family: Always   Never  Sometimes

Eats in front of television:  Always  Never  Sometimes

Does not eat much but has tendency to gain weight: Yes  No

Is your child particular about certain foods: Yes  No

If yes, to which ones: \_\_\_\_\_

Have you previously tried diets to help your child lose weight:  Yes  No

If yes, which one(s): **low carbohydrate** \_\_\_\_\_

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Is your child on a special diet: Yes  No

If yes, which one(s): \_\_\_\_\_

Does family eat between meals: Yes  No

What is eaten for snacks: (please circle)

- |   |              |          |
|---|--------------|----------|
| <input checked="" type="radio"/> 0-Cookies/Cakes              | 3-Sandwiches | 6-Yogurt |
| <input type="radio"/> 1- Fresh Fruit (whole fruit, not juice) | 4-Granola    | 7-Nuts   |
| <input checked="" type="radio"/> 2-Chips                      | 5-Cereal     | 8-Candy  |

What time of day is the child most hungry: **PLEASE CIRCLE**

- 0-Morning
- 1-Afternoon
- 2-Evening
- 3-Late Night

How many times a day does the child say she or he is hungry: 0 – 1 – 2 –  3 – 4 – 5 - More

Does the child eat before going to bed: Yes  No  what is eaten: \_\_\_\_\_

What does your child usually choose to drink: **PLEASE CIRCLE ALL THAT APPLY**

- 0-Soda how much per day (ounces or cups): **6 cups** \_\_\_\_\_
- 1-Juice how much per day (ounces or cups): **24 oz** \_\_\_\_\_
- 2-Water how much per day (ounces or cups): \_\_\_\_\_
- 3-Milk how much per day (ounces or cups): \_\_\_\_\_
- 4-Other: \_\_\_\_\_

Is food hidden or eaten in secret by family members: Yes  No  Who: \_\_\_\_\_

Is there a history of eating disorders in the family: Yes  No

If yes, please explain: \_\_\_\_\_

Have any contributed to your child's weight problems: **CIRCLE ALL THAT APPLY**

- |  |   |
|--|---|
| <input checked="" type="radio"/> 0-Boredom | <input checked="" type="radio"/> 7-Eating Out   |
| <input type="radio"/> 1-Stress             | 8-Snacking                                      |
| <input type="radio"/> 2-Anger              | 9-Holidays                                      |
| <input type="radio"/> 3-Happiness          | <input checked="" type="radio"/> 10-No Activity |
| <input checked="" type="radio"/> 4-Sadness | 11-Genetics                                     |
| <input type="radio"/> 5-Food as Reward     | 12-Lack of Planning                             |
| <input type="radio"/> 6-Portions           | 13-Smell/Sight of Food                          |

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**PAST MEDICAL HISTORY:**

What childhood illnesses have your child been treated for: **chicken pox** \_\_\_\_\_

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

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

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

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

If yes, please list: \_\_\_\_\_

**ALLERGIES:**

Allergy to Food: Yes  No, please list: \_\_\_\_\_

Allergy to Medicine: Yes  No, please list: \_\_\_\_\_

Allergy to Latex: Yes  No

**FAMILY HISTORY:**

Biological Parents:

Mother: Age: **43** Ht: **5'2"** Current Wt: **170** Most you've weighed: **177**

Father: Age: **46** Ht: **5'9"** Current Wt: **220** Most you've weighed: **232**

Siblings:	Age	Ht.	Wt.	Male/Female
<input checked="" type="radio"/> Full - Half - Step	<b>9</b>	<b>4'2"</b>	<b>100</b>	<input checked="" type="radio"/> 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...)**

- |  |  |  |  |
|--|--|--|--|
| <input checked="" type="radio"/> Diabetes  | Thyroid Problems                               | <input checked="" type="radio"/> Obesity | Weight loss surgery                                |
| Peptic Ulcer                               | Reflux   | Cancer                                   | Eating disorders                                   |
| Gallbladder                                | Liver disease                                  | ADHD                                     | Seizure  |
| Pancreatitis                               | Constipation                                   | Anxiety                                  | Depression   |
| <input checked="" type="radio"/> Arthritis | <input checked="" type="radio"/> Hypertension  | Mental Retardation                       | <input checked="" type="radio"/> Learning problems |
| Stroke                                     | <input checked="" type="radio"/> Heart disease | Personality disorder                     | Other: _____                                       |
| Infertility                                | Kidney disease                                 | Schizophrenia                            |  |

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**SOCIAL HISTORY:**

Caregiver marital status: **PLEASE CIRCLE**

0-Married    1-Divorced    2-Separated    3-Single    4-Widowed

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

0-Mother     1-Father     2-Sibling(s)     3-Grandparent(s)    4-Extended Family

Does your child go to day care: Yes  No,  Sitter: Yes  No

What is the quality of your child's relations with other kids: Poor   Fair Average Excellent

Is your child happy:  Yes  No, please explain: \_\_\_\_\_

What school and grade is your child in: **Jones Elementary, fifth grade**

How is your child's school performance: Poor   Fair Average Excellent

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

If yes, please detail: \_\_\_\_\_

Hours of television/night: **3** Computer/night: **1** Video games/night: **1**

If your child plays video games, what kind: **Dance Dance Revolution**

How does your child spend free time? Please explain: **Watching TV, surfing the net**

Child's energy level:  Low Average High

Physical activity at home: **None** Parents involved: Yes  No

Physical Education at school: Yes  No  How often: \_\_\_\_\_

Hours of after-school organized sports a week: **0**

Mother's highest level of education: **PLEASE CIRCLE**

- 0-High School
- 1-GED
- 2-Some College
- 3-College Degree
- 4-Graduate Degree

Mother's Occupation: **Insurance Agent** and number of hours worked/week: **40**

Father's highest level of education: **PLEASE CIRCLE**

- 0-High School
- 1-GED
- 2-Some College
- 3-College Degree
- 4-Graduate Degree

Father's Occupation: **Construction** and number of hours worked/week: **50**

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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: **No** \_\_\_\_\_

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: **Grandma** \_\_\_\_\_

**DEVELOPMENTAL HISTORY: AT WHAT AGE DID YOUR CHILD**

- 0-Sit Up: **6 mo** \_\_\_\_\_
- 1-Walk: **11 mo** \_\_\_\_\_
- 2-First Word: **9 mo** \_\_\_\_\_
- 3-Toilet Train: **17 mo** \_\_\_\_\_

**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:

			Comments
Allergy	<input checked="" type="radio"/> Yes	<input type="radio"/> No	<b>strawberries, ragweed</b> _____
Bleeding Tendency	<input type="radio"/> Yes	<input checked="" type="radio"/> No	_____
Headaches	<input type="radio"/> Yes	<input checked="" type="radio"/> No	_____
Morning Headaches	<input type="radio"/> Yes	<input checked="" type="radio"/> No	_____
Trouble breathing	<input type="radio"/> Yes	<input checked="" type="radio"/> No	_____
Shortness of Breath	<input checked="" type="radio"/> Yes	<input type="radio"/> No	<b>when he runs</b> _____
Heavy Breathing	<input type="radio"/> Yes	<input checked="" type="radio"/> No	_____
Asthma	<input type="radio"/> Yes	<input checked="" type="radio"/> No	_____
Snoring	<input type="radio"/> Yes	<input checked="" type="radio"/> No	Sleep study: <b>no</b> _____
Snores Loudly	<input type="radio"/> Yes	<input checked="" type="radio"/> No	_____
Mouth open during the day	<input checked="" type="radio"/> Yes	<input type="radio"/> No	_____
Heartburn	<input checked="" type="radio"/> Yes	<input type="radio"/> No	_____
Abdominal Pain	<input type="radio"/> Yes	<input checked="" type="radio"/> No	_____
Constipation	<input type="radio"/> Yes	<input checked="" type="radio"/> No	_____
Diarrhea	<input type="radio"/> Yes	<input checked="" type="radio"/> No	_____
Bedwetting/urinary problems	<input type="radio"/> Yes	<input checked="" type="radio"/> No	_____
Joint problems	<input type="radio"/> Yes	<input checked="" type="radio"/> No	_____
Tired in the morning	<input type="radio"/> Yes	<input checked="" type="radio"/> No	_____
Sleepy in school	<input type="radio"/> Yes	<input checked="" type="radio"/> No	_____
Easily distracted	<input checked="" type="radio"/> Yes	<input type="radio"/> No	_____

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*Date of Birth \_\_\_\_\_*

- |                              |                                      |                          |       |
|------------------------------|--------------------------------------|--------------------------|-------|
| Difficulty organizing        | <input checked="" type="radio"/> Yes | <input type="radio"/> No | _____ |
| Interrupts conversations     | <input checked="" type="radio"/> Yes | <input type="radio"/> No | _____ |
| Wears glasses                | <input checked="" type="radio"/> Yes | <input type="radio"/> No | _____ |
| Trouble following directions | <input checked="" type="radio"/> Yes | <input type="radio"/> No | _____ |
| Irregular period             | <input checked="" type="radio"/> Yes | <input type="radio"/> No | _____ |

Has your child ever been treated for the following conditions:

- |                          |                                      |                          | Comments              |
|--------------------------|--------------------------------------|--------------------------|-----------------------|
| ADHD                     | <input checked="" type="radio"/> Yes | <input type="radio"/> No | _____                 |
| ODD                      | <input checked="" type="radio"/> Yes | <input type="radio"/> No | _____                 |
| Anxiety                  | <input checked="" type="radio"/> Yes | <input type="radio"/> No | _____                 |
| Depression               | <input checked="" type="radio"/> Yes | <input type="radio"/> No | _____                 |
| Mental Health Conditions | <input checked="" type="radio"/> Yes | <input type="radio"/> No | please describe _____ |
| Legal issues             | <input checked="" type="radio"/> Yes | <input type="radio"/> No | _____                 |

FOR THE CHILD TO ANSWER: Do you want to lose weight?     Yes    No

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**EXERCISE LOG: Please keep track of your daily activities for three (3) days.**

<b>DAY</b>	<b>DATE</b>	<b>EXERCISE</b>	<b>MINUTES/STEPS</b>
Monday	4/10	Jump Rope	10 min
Wednesday	4/12	Walking	20 min
Thursday	4/13	Walked the Dog	15 min

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**WEIGH SMART<sup>®</sup> PROGRAM FOOD INTAKE RECORD** (to be recorded before returning this form)

Name of Child: Josh Lopez Dates Recorded: 4/10-4/13

Instructions: Write down everything your child eats (include sauces and drinks) **during the next 3 days**. To ensure accurate results, record the information whenever anything is eaten and/or any beverages.

Day	Time of Day	Food/Drink Description	Amount Eaten	Location of meal	How I feel
1	8:00am	Orange Juice 12 oz, lucky charms cereal with Whole Milk	1 bowl	In front of TV	Still Hungry
	12:00pm	Chicken nuggets, large fries, large coke	6 pc nuggets, all fries	Cafeteria at school	Full
	3:00pm	Peanut butter jelly sandwich, coke	Half	On bed	Still hungry
	6:00pm	Baked chicken, mashed potatoes, green beans, vanilla ice cream, coke	1 plate	In front of TV	Full

