



Mt. Washington Pediatric Hospital

Weigh Smart® Program

New Patient Information Form

1708 West Rogers Avenue ♦ Baltimore, Maryland 21209-4596
(410) 578-5343 ♦ FAX: (410) 578-2654

Place Label Here or Insert

Last Name, First Name

Med Rec # _____ and

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: _____

Name of person completing the form and relationship to child: _____

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

Patient Name: _____

Date of Birth: _____ Age: _____ Current Weight: _____ Ht: _____

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

0-Caucasian

3-Asian

1-African American

4-Other _____

2-Hispanic

Address: _____

Telephone: Home: _____

E-mail Address: _____

Parent's name: _____ Work Telephone: _____

Referring Physician: _____ Phone: _____

Why are you interested in our program: _____

BIRTH HISTORY:

Weight: _____ Length: _____ Full Term: Yes No Premature: Yes No

Which hospital? _____

If premature, at what week was child born: _____

Please Describe:

Problems during pregnancy: Yes No _____

Problems during delivery: Yes No _____

Problems in the first month: Yes No _____

FEEDING HISTORY:

Breast fed: Yes No

If yes, how long: _____ and if yes please circle one: **Pumped** or **Nursed**

What infant formulas were used: _____

At what age were rice cereal and baby foods introduced: _____

What foods do you avoid giving to your child: _____

Is there a history of feeding disorders: Yes No

If yes, what kind: _____

*Last Name, First Name**Med Rec # _____ and**Date of Birth _____***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**

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

3-Grandparent

4-Child

5-Child and Parent

6-Child and Grandparent

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

How many meals eaten outside the home/ week: _____ Where: _____

Does the child eat school breakfast? Yes or No School lunch? Yes or No

Favorite foods: _____

Favorite drinks: _____

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 any of your children lose weight: Yes No

If yes, which one(s): _____

Is your child on a special diet: Yes No

If yes, which one(s): _____

Does the family eat between meals: Yes No

What is eaten for snacks frequently (at least once a week)? **PLEASE CIRCLE:**

0-Cookies/Cakes

3-Sandwiches

6-Yogurt

1- Fresh Fruit (whole fruit,not juice)

4-Granola

7-Nuts

2-Chips

5-Cereal

8-Candy

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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): _____
- 1-Juice how much per day (ounces or cups): _____
- 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? **PLEASE CIRCLE ALL THAT APPLY:**

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

PAST MEDICAL HISTORY:

What childhood illnesses have your child been treated for: _____

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

Immunizations up to date? Yes No

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

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 or do you use a 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: _____

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: _____ Computer/night: _____ Video games/night: _____

If your child plays video games, what kind: _____

How does your child spend free time? Please explain: _____

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

Child's energy level: Low Average High

Physical activity at home: _____ Parents involved: Yes No

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

Hours of after-school organized sports a week: _____

Does anyone smoke in the home or around the child? Yes No

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: _____ 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

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: _____

DEVELOPMENTAL HISTORY: AT WHAT AGE DID YOUR CHILD

- 0-Sit Up: _____
- 1-Walk: _____
- 2-First Word: _____
- 3-Toilet Train: _____

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

REVIEW OF SYSTEMS:

Place Label Here or Insert
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Does your child have any of these symptoms:

	Comments	
Allergy	Yes No	_____
Bleeding Tendency	Yes No	_____
Recurrent Headaches	Yes No	_____

If yes: At least 5 separate headaches severe enough to require he/she stop activities or take pain medication

	Yes	No	
Headaches accompanied by nausea or vomiting	Yes	No	
Headaches with sensitivity to light	Yes	No	

Headaches with visual disturbances and/or temporary numbness/tingling Yes No

Morning Headaches	Yes	No	_____
Trouble breathing	Yes	No	_____
Shortness of Breath	Yes	No	_____
Heavy Breathing	Yes	No	_____
Asthma	Yes	No	_____
Snoring	Yes	No	Sleep study: _____
Snores Loudly	Yes	No	_____
Mouth open during the day	Yes	No	_____
Heartburn	Yes	No	_____
Abdominal Pain	Yes	No	_____
Constipation	Yes	No	_____
Diarrhea	Yes	No	_____
Bedwetting/urinary problems	Yes	No	_____
Joint problems	Yes	No	_____
Any other complaints of pain	Yes	No	_____
Tired in the morning	Yes	No	_____
Sleepy in school	Yes	No	_____
Easily distracted	Yes	No	_____
Difficulty organizing	Yes	No	_____
Interrupts conversations	Yes	No	_____
Wears glasses	Yes	No	_____
Trouble following directions	Yes	No	_____
Irregular period	Yes	No	_____

Has your child ever been treated for the following conditions: **Comments**

ADHD	Yes	No	_____
ODD	Yes	No	_____
Anxiety	Yes	No	_____
Depression	Yes	No	_____
Mental Health Conditions	Yes	No	please describe: _____
Legal issues	Yes	No	_____
Behavior issues	Yes	No	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)

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

Does your child have a history of being teased or bullied? Yes No
 If so, where _____

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

EXERCISE LOG: Please keep track of your daily activities for one day. **If you did not have any exercise or chores, please check the box below to acknowledge no activity during that time.**

Date	Exercise/Chores	Minutes/Steps

I did not have any physical activity/chores for this day.

FOOD INTAKE RECORD: Instructions: 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 Description	Amount Eaten	Location of Meal	How I Feel