



# Mt. Washington Pediatric Hospital

## Weigh Smart Jr. Program

### New Patient Preschool Information Form

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

Label or insert	
Last Name,	First Name
Med Rec. # _____	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 the person completing the form and relationship to child: \_\_\_\_\_

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

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Current Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Gender: PLEASE CIRCLE Female Male

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

0 – Caucasian

3 – Asian

1 – African American

4 – Other \_\_\_\_\_

2 – Hispanic

Mailing Address: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Why are you interested in our program? \_\_\_\_\_

### **BIRTH HISTORY:**

Weight: \_\_\_\_\_ Length: \_\_\_\_\_ Full Term: Yes No Premature: Yes No

Which hospital? \_\_\_\_\_

How long was he/she hospitalized? \_\_\_\_\_

If premature, how many weeks early was the child? \_\_\_\_\_

Problems during pregnancy? Yes No describe: \_\_\_\_\_

Problems during delivery? Yes No describe: \_\_\_\_\_

Problems in the first month? Yes No describe: \_\_\_\_\_

### **FEEDING HISTORY:**

Breast-fed: Yes No

If yes, how long? \_\_\_\_\_ and 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 problems? Yes or No If yes, what kind? \_\_\_\_\_

\_\_\_\_\_

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How often does your child have a bowel movement?  
\_\_\_\_\_

**EATING STYLE:**

Does your child eat large meals?                      Yes    No  
 Does your child like to nibble?                      Yes    No  
 Does your child skip meals?                      Yes    No    if yes which meals: \_\_\_\_\_

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

0 – Mother    1 – Father    2 – Both Parents    3-Grandparent

Who prepares the meals? **PLEASE CIRCLE ALL THAT APPLY**

0 – Mother    1 – Father    2 – Both Parents    3 – Grandparent

Number of restaurant meals per week: \_\_\_\_\_

Which restaurant(s): \_\_\_\_\_

How many meals eaten outside the home/week: \_\_\_\_\_ Where: \_\_\_\_\_

Does the child eat school breakfast/lunch or meals at daycare/pre-school?    Yes    No

Favorite foods: \_\_\_\_\_

Favorite drinks: \_\_\_\_\_

Eats at the table with family:                      Always              Never              Sometimes

Eats in front of the television:                      Always              Never              Sometimes

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

Is your child particular about certain foods?                      Yes    No

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

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

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

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 frequently (at least once a week)? **PLEASE CIRCLE**

- |             |  |
|-------------|--|
| 0 – Cookies | 1 – Fresh fruit (whole fruit, not juice) |
| 2 – Chips   | 3 – Sandwiches                           |
| 5 – Cereal  | 6 – Yogurt                               |
| 8 – Candy   |  |

What time of day is the child most hungry? **PLEASE CIRCLE ALL THAT APPLY**

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

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How many times a day does the child say he/she is hungry? **0 – 1 – 2 – 3 – 4 – 5 – More**

Does the child eat before going to bed? Yes No

If yes, 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): \_\_\_\_\_
- What kind?*    Whole          2%            1%          Skim
- 4 – Other     how much per day (ounces or cups): \_\_\_\_\_

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

What problem(s) does your child have with feeding? **CHECK ALL THAT APPLY**

- \_\_\_\_\_ Eats too fast
- \_\_\_\_\_ Takes food from others
- \_\_\_\_\_ Does not chew
- \_\_\_\_\_ Leaves table
- \_\_\_\_\_ Cries or tantrums
- \_\_\_\_\_ Picky eater
- \_\_\_\_\_ Sneaks food
- \_\_\_\_\_ Vomits/Gags
- Other \_\_\_\_\_

Is it hard to tell if your child is hungry? Yes No

Does your child have a predictable feeding schedule? Yes No

Does your child sleep through the night? Yes No

If not, why? \_\_\_\_\_

Do you have any concerns about your child’s development? Yes No

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

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

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Has your child had any special medical treatments for a medical condition?

Yes No If yes, please list: \_\_\_\_\_

**IMMUNIZATIONS AND ALLERGIES:**

Are immunizations up to date? Yes No  
 Any food allergies Yes No If yes, list \_\_\_\_\_  
 Any drug allergies Yes No If yes, list \_\_\_\_\_

**FAMILY HISTORY:**

Who lives in the home with your child? \_\_\_\_\_

Biological Parents:

Mother: Age: \_\_\_\_\_ Height: \_\_\_\_\_ Current Wt.: \_\_\_\_\_ Most you've weighed: \_\_\_\_\_

Father: Age: \_\_\_\_\_ Height: \_\_\_\_\_ Current Wt.: \_\_\_\_\_ Most you've weighed: \_\_\_\_\_

Siblings:	Age	Height	Weight	Gender
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, etc.)*

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

**SOCIAL HISTORY:**

Caregiver marital status: **PLEASE CIRCLE**

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

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

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

What school/daycare does your child attend? \_\_\_\_\_

Grade: \_\_\_\_\_

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

Any behavior issues at school or day care? If yes, please comment: \_\_\_\_\_

Does your child have an IEP or a 504 plan or early intervention service: 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. \_\_\_\_\_

Child's energy level: Low Average High

Physical activity at home: Yes No, please explain: \_\_\_\_\_

Parents involved? Yes No

Physical Education at school or play groups: Yes No If yes, how often? \_\_\_\_\_

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

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

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

Mother's Occupation: \_\_\_\_\_ Number of hours worked/week: \_\_\_\_\_

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

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

Father's Occupation: \_\_\_\_\_ Number of hours worked/week: \_\_\_\_\_

Primary caregiver's work schedule: **CIRCLE ALL THAT APPLY**

- |              |            |
|--------------|------------|
| 0 – Weekends | 2 – Days   |
| 1 – Weekdays | 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, state their relationship to your child: \_\_\_\_\_

**DEVELOPMENTAL HISTORY:**

At what age did your child:

- |                 |                         |
|-----------------|-------------------------|
| 1 – Walk: _____ | 2 – Toilet Train: _____ |
|-----------------|-------------------------|

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**MEDICATIONS:** Please list all medication within the last 3 months (include vitamins, health food remedies, etc.) \_\_\_\_\_

**REVIEW OF SYMPTOMS:**

				Comments
Does your child have any of these symptoms?				
Allergy	Yes	No		_____
Bleeding Tendency	Yes	No		_____
Headaches	Yes	No		_____
Morning Headaches	Yes	No		_____
Trouble Breathing	Yes	No		_____
Shortness of Breath	Yes	No		_____
Asthma	Yes	No		_____
Snoring	Yes	No		_____
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		_____
Interrupts Conversations	Yes	No		_____
Wears Glasses	Yes	No		_____
Trouble Following Directions	Yes	No		_____
Vomiting	Yes	No		_____
ADHD	Yes	No		_____
Mental Health Conditions	Yes	No		please describe: _____
Behavioral 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.)?      Yes      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 child’s daily activities for one day. If he/she did not have any exercise, play or chores, please check the box below to acknowledge no activity during that time.**

Date	Exercise/Chores/Active play	Minutes

**He/she did not have any physical activity/play or chores for this day.**

**FOOD INTAKE RECORD**

(to be recorded before returning this form)

Date Recorded: \_\_\_\_\_

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