



Mt. Washington Pediatric Hospital

Weigh Smart Jr. Program

New Patient Preschool Information Form

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

Label
Last Name, First Name
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: _____

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: _____

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

- | | |
|----------------------|-----------------|
| 0 – Caucasian | 3 – Asian |
| 1 – African American | 4 – Other _____ |
| 2 – Hispanic | |

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 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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Yes No

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

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? _____

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: _____ |
|-----------------|-------------------------|

MEDICATIONS: Please list all medication within the last 3 months

(include vitamins, health food remedies, etc.) _____

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REVIEW OF SYMPTOMS:

Does your child have any of these symptoms?			Comments
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	_____
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