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 ANY GROWTH CHARTS, LAB WORK RESULTS, AND/OR 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
Patient Name: _____ Sex:_____
Date of Birth: _____Age:_____ Current Weight: _____Ht: _____

Patient Ethnicity: (Please note: for informational purposes and is optional) **PLEASE CIRCLE**
0-Caucasian 1-African American 2-Hispanic 3-Asian 4-Other_____

Address: _____
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: _____
City, State, & Zip Code: _____
Referring Physician: _____ Phone: _____
Primary Care Physician: _____
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:_____

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: _____

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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 eat large meals: Yes No

Does your child eat quickly: Yes No

Likes to nibble: Yes No

Skips meal: Yes No If yes, which meal or meals? **Please Circle:** Breakfast Lunch Dinner

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

Does your child eat at before/after school care programs? Yes or No

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

If yes, which one(s): _____

ALLERGIES:

Allergy to Food: Yes No, please list: _____ _____

Allergy to Medicine: Yes No, please list: _____

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

Allergy to Latex: Yes No

Immunizations up to date Yes No

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

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

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

SOCIAL HISTORY:

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

Mother Father Sibling(s) Grandparent(s) Extended Family 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: _____

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

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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:

			Comments
Allergy	Yes	No	_____
Bleeding Tendency	Yes	No	_____
Recurrent Headaches	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	_____
Problems with balance/coordination	Yes	No	_____
Irregular period	Yes	No	n/a

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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) Yes No

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

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

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Please return your completed form to MWPH.

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

