Mt. Washington Pediatric Hospital

Weigh Smart® Program

New Patient Information Form

1708 West Rogers Avenue ♦ Baltimore, Maryland 21209-4596
*(410) 578-5145 or (410) 367-2222 ♦ **FAX:** (410) 578-2654*

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 and relationship to 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 3-Asian
1-African American 4-Other_____________
2-Hispanic

Parent(s) name(s): ____
Home Phone:_______________ Cell Phone: _______________ Work Phone: _______________
E-mail Address: ____
Address: ____
City, State, & Zip Code: ____
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 _____________________________

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: ____

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_________ ___________________________
Last Name First Name

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**

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

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: ____

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

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

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

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______ ____________________
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SOCIAL HISTORY:

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

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

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

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: ____

Physical activity at home: ______________________________ Parents involved: Yes   No

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

____

____

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REVIEW OF SYSTEMS:

Does your child have any of these symptoms:

Symptom			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

Symptom			Comments
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:

Condition			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:____________

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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____
____

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

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

Please return your completed form to MWPH.

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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

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