**Pediatric Weight Management Follow Up Visit**

**Regular MD:**

Last Name, First Name

Medical Number

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Age: ________ Yrs  Height:___________ in / cm

Smoker In Home? £ Yes £ No

Current Smoker? £ Yes £ No

Weight?___________ # / Kg

BP:_____ /_____

HR:_____________ # / min

BMI:_______/_______%

Patient Concerns:____________________________________ Date:__________

Allergies: £ None Accompanied By: £ Mom £ Dad £ Other:

**Phone:** ________________________________________________

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### HISTORY

**Chief Complaint/History of Present Illness**

£ Questions or Concerns

£ Self Esteem – Self Image

£ Perception of Weight & Health

£ Current Health Habits

Physical Activity (active play, sports)_____________________

Sedentary Time (TV, video games)_____________________

Nutrition

(sodas/juice/fast food, fruits/veg, dairy, portion sizes)

Eating Habits

(meal skipping, family meals, binging-purging)

£ Successes & Barriers

£ Areas Chosen by Family to Work On

£ Readiness to Change (child vs parent)_________________

£ Health Goals

£ Rewards

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### REVIEW OF SYSTEMS

<table>
<thead>
<tr>
<th>No Problem</th>
<th>Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Constitutional</strong></td>
<td></td>
</tr>
<tr>
<td>£ Fatigue / Lethargy</td>
<td></td>
</tr>
<tr>
<td>£ Fever</td>
<td></td>
</tr>
<tr>
<td><strong>HEENT</strong></td>
<td></td>
</tr>
<tr>
<td>£ Ear Pain</td>
<td></td>
</tr>
<tr>
<td>£ Runny Nose</td>
<td></td>
</tr>
<tr>
<td>£ Snoring</td>
<td></td>
</tr>
<tr>
<td>£ Sore throat</td>
<td></td>
</tr>
<tr>
<td><strong>Respiratory</strong></td>
<td></td>
</tr>
<tr>
<td>£ Cough</td>
<td></td>
</tr>
<tr>
<td>£ Difficulty Breathing (noc)</td>
<td></td>
</tr>
<tr>
<td>£ Wheezing / Stridor</td>
<td></td>
</tr>
<tr>
<td><strong>Cardiovascular</strong></td>
<td></td>
</tr>
<tr>
<td>£ Chest Pain</td>
<td></td>
</tr>
<tr>
<td>£ All other systems negative</td>
<td></td>
</tr>
<tr>
<td><strong>Gastrointestinal</strong></td>
<td></td>
</tr>
<tr>
<td>£ Abdominal Pain</td>
<td></td>
</tr>
<tr>
<td>£ Vomiting</td>
<td></td>
</tr>
<tr>
<td>£ Skin</td>
<td></td>
</tr>
<tr>
<td>£ Striae</td>
<td></td>
</tr>
<tr>
<td><strong>Neurologic</strong></td>
<td></td>
</tr>
<tr>
<td>£ Developmental Delay</td>
<td></td>
</tr>
<tr>
<td>£ Headache</td>
<td></td>
</tr>
<tr>
<td>£ Genitourinary</td>
<td></td>
</tr>
<tr>
<td>£ Menarche</td>
<td></td>
</tr>
<tr>
<td>£ Oligo / Amenorrhea</td>
<td>L.M.P.:________</td>
</tr>
<tr>
<td><strong>Musculoskeletal</strong></td>
<td></td>
</tr>
<tr>
<td>£ Limp</td>
<td></td>
</tr>
<tr>
<td>£ Knee / Hip Pain</td>
<td></td>
</tr>
<tr>
<td>£ Allergy</td>
<td></td>
</tr>
<tr>
<td>£ Medication Allergy</td>
<td></td>
</tr>
</tbody>
</table>

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### MEDICATIONS

£ None

£ See History

£ See Chronic Med List

£ Acetaminophen

£ Ibuprofen

£ Metformin

£ Other________________________
**PHYSICAL EXAM**

<table>
<thead>
<tr>
<th>NL</th>
<th>AB</th>
<th>Abnormal Findings:</th>
</tr>
</thead>
<tbody>
<tr>
<td>£1</td>
<td>Eyes (no conjunctival infection, no papilledema)</td>
<td>£</td>
</tr>
<tr>
<td>£2</td>
<td>ENT (no ear pain, TM’s clear, nasal mucosa nl, teeth/gums nl, oral-pharynx nl, mucous memb moist)</td>
<td>£</td>
</tr>
<tr>
<td>£3</td>
<td>Neck (supple, no adenopathy/masses, thyroid nl)</td>
<td>£</td>
</tr>
<tr>
<td>£4</td>
<td>Resp (clear by auscultation, no retractions)</td>
<td>£</td>
</tr>
<tr>
<td>£5</td>
<td>Abd (nontender, no mas/organomegaly, bowel sounds nl)</td>
<td>£</td>
</tr>
<tr>
<td>£6</td>
<td>Skin (no striae, no hirsutism, no acanthosis nigricans)</td>
<td>£</td>
</tr>
<tr>
<td>£7</td>
<td>Psych (normal affect and memory)</td>
<td>£</td>
</tr>
</tbody>
</table>

**Assessment**

- Weight Change Since Last Visit:
  - Child Readiness to Change
  - Parent Readiness to Change
  - Areas of Improvement
- Nutrition
- Self-Esteem
- Other:

**Medications**

- CBC
- UA
- Fasting Cholesterol/Lipid Panel
- Fasting Blood Glucose
- Fasting Insulin
- Random Glucose
- HgbA1C
- TSH/Free T4
- SGPT/SGO/Billirubin
- X Ray:
- Old Records Reviewed

**Immunizations**

- DTAP
- Hep B
- Con-Pneumo
- V-Z
- Td
- IPV
- HIB
- MMR
- Hep A
- Influenza

**Counseling - Information**

- Patient/Family Goals
- Environmental Tobacco Smoke
- Smoking cessation / Advised to Quit

- Counseling:
  - Activity/Exercise
  - Nutrition/Eating Habits
  - Self-Esteem
  - Body Acceptance
  - Other:

- Written Information:
  - Tip Sheet
  - Health Goals Spreadsheet
  - Other:

- Referral To:
  - Dietician
  - Weight Management Program
  - Mental Health
  - Other:

**Plan**

- RTC: PRN

**Sign Here...**

**Date Here...**