Pediatric Weight Management Initial Visit

Age: ________ Yrs  Height: _________ in / cm
Smoker In Home?  ☐ Yes ☐ No  Weight? _________ # / Kg
BP: _____ / _____
Current Smoker?  ☐ Yes ☐ No  HR: _________ # / min
BMI: _________ / _______

Patient Concerns: __________________________________________ Date: ___________

Allergies: ____________________________________________  ☐ None
Accompanied By: □ Mom □ Dad □ Other:
Phone: ________________________________

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________________________

REVIEW OF SYSTEMS

☐ No Problem  ☐ Problem

☐ Constitutional

  Depression________________________

  Fatigue / Lethargy________________________

  Fever________________________

  HEENT

  Ear Pain________________________

  Runny Nose________________________

  Snoring________________________

  Sore throat________________________

  Respiratory

  Cough________________________

  Difficulty Breathing (noc)________________________

  Wheezing / Stridor________________________

☐ Cardiovascular

  Chest Pain________________________

  All other systems negative________________________

☐ No Problem  ☐ Problem

☐ Gastrointestinal

  Abdominal Pain________________________

  Vomiting________________________

  Skin________________________

  Striae________________________

  Neurologic

  Developmental Delay________________________

  Headache________________________

  Genitourinary

  Menarche________________________

  Oligo / Amenorrhea________________________

  L.M.P.:________________

  Musculoskeletal

  Limp________________________

  Knee / Hip Pain________________________

  Allergy________________________

  Medication Allergy________________________

☐ No Problem  ☐ Problem

☐ Past-Family-Social History

☐ Tobacco Exposure Noted Above________________________

☐ Immunizations Reviews________________________

☐ Medical Record Reviewed________________________

☐ Family History________________________

  ☐ Obesity/Overweight________________________

  ☐ Type 2 Diabetes________________________

  ☐ Hypertension________________________

  ☐ Cardiovascular Disease________________________

  ☐ Depression________________________

Interpreter Used: □ No  □ Yes - Language: __________________________

☐ None  ☐ See History  ☐ See Chronic Med List  ☐ Acetaminophen  ☐ Ibuprofen  ☐ Metformin  ☐ Other________________________

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**PHYSICAL EXAM**

<table>
<thead>
<tr>
<th></th>
<th>Abnormal Findings:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Constitutional (alert, not toxic, not dysmorphic)</td>
</tr>
<tr>
<td>2</td>
<td>Eyes (no conjunctival infection, no papilledema)</td>
</tr>
<tr>
<td>3</td>
<td>ENT (no ear pain, TM’s clear, nasal mucosa nl, teeth/gums nl, oral-pharynx nl, mucous memb moist)</td>
</tr>
<tr>
<td>4</td>
<td>Neck (supple, no adenopathy/masses, thyroid nl)</td>
</tr>
<tr>
<td>5</td>
<td>Resp (clear by auscultation, no retractions)</td>
</tr>
<tr>
<td>6</td>
<td>Heart (regular rhythm, no murmur)</td>
</tr>
<tr>
<td>7</td>
<td>Skin (no striae, no hirsutism, no acanthosis nigricans)</td>
</tr>
<tr>
<td>8</td>
<td>Extr (no cyanosis, pulses &amp; perfusion nl, no edema)</td>
</tr>
<tr>
<td>9</td>
<td>Musc (nl gait, full ROM without pain, no tibial bowing)</td>
</tr>
<tr>
<td>10</td>
<td>GU</td>
</tr>
<tr>
<td>11</td>
<td>Tanner Stage (genital/breast):</td>
</tr>
<tr>
<td>12</td>
<td>Tanner Stage (pubic hair):</td>
</tr>
<tr>
<td>13</td>
<td>Neuro (DTR 2+, CN 2-12 nl)</td>
</tr>
</tbody>
</table>

**WEIGHT CHANGE SINCE LAST VISIT**

- Child Readiness to Change
  - High
  - Medium
  - Low
- Parent Readiness to Change
  - High
  - Medium
  - Low

**AREAS OF IMPROVEMENT**

- Activity
- Nutrition
- Self-Esteem
- Other:

**MEDICATIONS**

- CBC
- UA
- Fasting Cholesterol/Lipid Panel
- Fasting Blood Glucose
- Fasting Insulin
- Random Glucose
- HgbA1C
- TSH/Free T4
- SGPT/SGO/Bilirubin
- 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**

- Mental Health
- Other:

**RTC:** PRN __________ wk/month

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

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

**Sign Here...**

**Date Here...**