Lucile Salter Packard Children's Hospital
STANFORD UNIVERSITY MEDICAL CENTER
725 Welch Road Palo Alto, CA 94304

Medical Record Number

Patient Name

Addressograph or Label

Date of Visit:

PATIENT INFORMATION

1) Child's Last Name First Middle	2) Date of Birth (mm/dd/yy)

3) Your relationship to child: ❑ Biological mother ❑ Biological father ❑ Other (specify)	4) REFERRING MD INFORMATION: Name and address

5a) Current Height (in)	5b) Current Weight (lbs)	6) When did you first notice that your child weighed more than other children the same age? _____ years old
		7) Child's maximum weight ever (lbs) At what age (years)

CONCERNS ABOUT WEIGHT

8) How concerned are you about your child's weight? (Circle the best answer.)

Not at All	A little	Pretty much	A lot	Very Much
1	2	3	4	5

Please rate the following types of concerns about your child's weight. (Circle the number from 1 to 5 that best represents your level of concern.)

	Not at all	A little	Pretty Much	A lot	Very much
9) Health issues at present	1	2	3	4	5
10) Health issues in the future	1	2	3	4	5
11) Teasing	1	2	3	4	5
12) Low self-esteem	1	2	3	4	5
13) Depression	1	2	3	4	5
14) Interference with physical activity	1	2	3	4	5
15) Clothes don't fit	1	2	3	4	5
16) Other concern(s)	1	2	3	4	5

17) Have any of the following people expressed concern about your child's weight?	❑ **YES** ❑Doctor ❑Child's other parent ❑Aunt ❑Coach ❑Brother or sister ❑Uncle ❑Teacher ❑Grandmother ❑Someone else ❑Friend ❑Grandfather	❑ **NO**

In your opinion, what factors are causing your child to be overweight? (Check the best answer for each question.)	Yes	No	Not sure
18) Eating too much			
19) Eating the wrong kinds of food			
20) Not enough exercise			
21) Too much TV			
22) Too many video games			
23) Too much time on the computer or internet			
24) Genetics (it runs in the family)			
25) Gland or hormone problem			
26) Other medical problem			
27) Life event			

WEIGHT LOSS ATTEMPTS

28) Has your child tried any weight loss diets or programs?		❑ **YES**		❑ **NO**
		Helped	Didn't Help	
	❑Atkins Diet			
	❑Committed to Kids			
	❑Curves			
	❑Jenny Craig			
	❑Kaiser			
	❑Kidshape			
	❑Low carb diet			
	❑Low fat diet			
	❑Low glycemic index diet			
	❑Shapedown			
	❑South Beach Diet			
	❑Stanford Program			
	❑TOPS			
	❑Weight Watchers			
	❑Zone			
	❑Other			

29) Has your child tried any weight loss medications or supplements?		❑ **YES**			❑ **NO**
		Helped	Didn't Help		
	❑Sibutramine (Meridia)				
	❑Orlistat (Zenical)				
	❑Metabolife				
	❑Herbal Life				
	❑Vitamins				
	❑Other supplement				
30) What methods is your child currently using to try to lose weight?	❑Eat less				❑ NONE
	❑ Decrease portion size				
	❑ Cut out meals				
	❑Cut out a certain food				
	❑Eat more of a certain food				
	❑Diet plan				
	❑Exercise more				
	❑ Go to a gym				
	❑Weight control program				
	❑Weight loss supplement				
31) Is anyone else in the family trying to lose weight?	❑ **YES**	How?			❑ **NO**
	❑Biological mother				
	❑Biological father				
	❑Step-mother				
	❑Step-father				
	❑Sister				
	❑Brother				
	❑Grandmother				
	❑Grandfather				
	❑Other				
32) How confident are you that your child can lose weight by changes in diet and activity? (Circle the best answer from 1 to 5.)	Not at all confident				Very Confident
	1	2	3	4	5

PAST MEDICAL HISTORY

33) Birth history: ❑early ❑ late ❑ on time	34) Birth weight (pounds & ounces OR kilograms)	35) Fed breast milk until what age? (months)	
36) Received formula by bottle starting when? ❑ birth ❑ age:_____ months	Name of formula(s) used?	37) Completely weaned from the bottle at what age?(months)	38) First started cereals at what age? (months)

39) Were there any infant feeding problems before one year of age?	❑ **YES** Explain:	❑ **NO**
40) Were there any feeding problems after one year of age?	❑ **YES** Explain:	❑ **NO**

41) Mother's problems during pregnancy: (Check all that apply)

❑ None
❑ Diabetes
❑ Vomiting to control weight
❑ High blood pressure (hypertension)
❑ Too little weight gain
❑ Binge eating
❑ Too much weight gain
❑ Other (specify:_____)

42) Child's medical problems as a newborn: (Check all that apply)

❑None
❑Infection
❑Jaundice
❑Breathing problems
❑Floppy muscles
❑Poor growth

43) Has your child had all of his or her shots for age?

❑ YES
❑ NOT SURE
❑ NO

44) **HOSPITALIZATIONS** (staying overnight in a hospital): ❑ None

Age	Month/Year	Reason	Name of Hospital

45) **SURGERY** (operations): ❑ None

Age	Month/Year	Reason	Name of Hospital

MEDICAL PROBLEMS: (Check the best answer for each question.)

	Never	In the past	Now
46) ADHD/ADD/hyperactivity			
47) Anemia			
48) Anorexia			
49) Anxiety			
50) Asthma			
51) Binge Eating			
52) Depression			
53) Diabetes (❑type 1 ❑type 2)			
54) Gastroesophageal reflux			
55) Heart problem			
56) High blood pressure			
57) High cholesterol			
58) Joint problem			
59) Kidney problem			
60) Liver problem			
61) Polycystic ovary syndrome			
62) Vomiting to control weight			
63) Other medical problem			

64) Current Medications: ❑ None

65) Vitamins and Minerals: ❑ None

66) Herbs and other dietary supplements: ❑ None

67) Allergies to food or medicine: ❑ None

REVIEW OF SYSTEMS		
Does your child currently have any of the following problems? (Check yes or no for each question.)	**YES**	**NO**
68) Blurry vision		
69) Headaches		
70) Nasal congestion/allergies		
71) Snoring		
72) Sleep apnea (pauses in breathing during sleep)		
73) Daytime sleepiness		
74) Dental caries/cavities		
75) Acne		
76) Eczema (skin allergy)		
77) Excess hair growth on skin		
78) Darkening of the skin on the neck, under the arms, or around the waist		
79) Breast enlargement (apart from normal development)		
80) Irregular menstrual periods		
81) Paleness		
82) Chest pain		
83) Shortness of breath with exercise		
84) Stomach aches		
85) Vomiting		
86) Diarrhea		
87) Constipation		
88) Urinary tract infections		
89) Bedwetting		
90) Nocturia (waking up at night to use the bathroom)		
91) Daytime leakage of urine		
92) Extra urination		
93) Extra thirst		
94) Recent unintended weight loss		
95) Back pain		
96) Hip pain		
97) Knee pain		
98) Behavior problem		
FAMILY HISTORY		
	Height	Weight
99) Biological mother of child		
100) Biological father of child		

Please check all the biological relatives of your child on either side of the family that currently have or have in the past had these conditions. If none, leave blank.
Code: MO= mother, FA= father, GM= grandmother, GF= grandfather, AU= aunt, UN= uncle

	MOTHER'S SIDE					FATHER'S SIDE					
	MO	GM	GF	AU	UN	FA	GM	GF	AU	UN	Other
101) Overweight											
102) High cholesterol											
103) High blood pressure											
104) Diabetes											
105) Heart Attack											
106) Stroke											
107) Cancer											
108) Thyroid problem											
109) Gallbladder problem											
110) Polycystic ovaries											
111) Eating disorder											
112) Alcoholism											
113) Depression											
114) Anxiety											
115) Substance abuse											
116) Weight loss surgery											

117) Are there any other medical problems that run in the family?

HOME LIFE

118) Mother's place of birth: (country)	119) Father's place of birth: (country)	120) Child's place of birth: (country)

121) If your child was born outside of the US, how old was he/she when you moved here? (years)	122) What languages are spoken at home? (Check all that apply.) ❑English ❑Spanish ❑Other:_____

123) Who currently lives at home with your child? (Check all that apply.)

❑ Biological mother
❑ Biological father
❑ Step-father or mother's boyfriend
❑ Step-mother or father's girlfriend
❑ Grandmother
❑ Grandfather

❑ Brother(s): ages _____
❑ Sister(s): ages_____
❑ Other relatives: (who?_____)
❑ Roommates: (how many?_____adults _____kids)

124) Does your child spend time with another parent in a different home?	❑ **YES** Explain:	❑ **NO**
125) Does your child have siblings that live in a different home?	❑ **YES** ❑brothers; ages:_____ ❑sisters; ages:_____	❑ **NO**

126) Do you have any pets at home?	❑ **YES** what kind?	❑ **NO**
127) Does anyone smoke at home, either inside or outside?	❑ **YES**	❑ **NO**

EATING AND PHYSICAL ACTIVITY

128) Who does most of the food shopping for the family? ❑ Mother ❑ Father ❑ Other (who?_____)	129) Who cooks most of the meals in the family? ❑ Mother ❑ Father ❑ Other (who?_____)	
130) How often does your child eat out at restaurants of any kind? ❑ Once a day ❑ Two or more times per day ❑ Several times per week ❑ About once a week ❑ About once a month ❑ Less than once a month	131) What restaurants does your child go to most often, including fast food restaurants?	
132) Does your child buy snacks from a supermarket, convenience store, or fast food outlet near your home?	❑ **YES** Name:	❑ **NO**
133) Does your child buy snacks from a food cart or ice cream truck that comes to your neighborhood?	❑ **YES** how often?	❑ **NO**
134) Does your child drink soda?	❑ **YES** ❑regular soda (how much per day?_____) ❑diet soda (how much per day?_____)	❑ **NO**
135) Does your child drink juice?	❑ **YES** how much per day?	❑ **NO**
136) Does your child drink milk? (Check all that apply.)	❑ **YES** ❑Fat-free or skim milk (how much per day?_____) ❑1% or low-fat milk (how much per day?_____) ❑2% or reduced fat milk (how much per day?_____) ❑Whole milk (how much per day?_____) ❑Soy milk (how much per day?_____)	❑ **NO**

	Not at all	A little	Pretty Much	A lot	Very much
137) Does your child like fruit?	1	2	3	4	5
138) Does your child like vegetables?	1	2	3	4	5

139) Does the family sit down to eat meals together? (Circle the best answer from 1 to 5.)

Never	Hardly ever	Sometimes	Most of the time	Always
1	2	3	4	5

140) Is the TV usually on during dinner?	❑ **YES**	❑ **NO**
141) Does your child have a TV in his or her bedroom?	❑ **YES**	❑ **NO**

How many hours PER DAY does your child participate in the following activities?

	during the week	during the weekend
142) Watching TV or videos		
143) Playing video games		
144) Using the computer		

145) Does your child do any chores at home?	❑ **YES** which ones?	❑ **NO**
146) Do you have a scale in your home?	❑ **YES** If so, how often do you weigh your child?	❑ **NO**
147) Does your child usually eat breakfast before school?	❑ **YES** how many days per week?	❑ **NO**
148) Child's current grade in school:	149) How does your child get to and from school? (Check all that apply.) ❑ Walks ❑ Rides a bicycle ❑ By bus ❑ By car	
150) Does your child have PE at school?	❑ **YES** How many days per week?	❑ **NO**

151) Does your child participate in any team sports at school or elsewhere? (Check all that apply.)

❑ Baseball ❑ Football ❑ Basketball ❑ Soccer	❑ Other (specify:_____)

152) Does your child do any other physical activities outside of school? (Check all that apply.)

- ❑ Bowling
- ❑ Dancing
- ❑ Go to the park
- ❑ Karate/martial arts
- ❑ Basketball (not on a team)
- ❑ Football (not on a team)
- ❑ Soccer (not on a team)
- ❑ Ride a bike
- ❑ Rollerblading
- ❑ Running
- ❑ Swimming
- ❑ Walking
- ❑ Walk the dog
- ❑ Other (specify:_____)

Date	Signature:
	Relationship to Patient:

THANK YOU FOR YOUR ANSWERS!

Instructions to Attending Physicians:
Your signature below indicates that you have reviewed the information contained in the entire questionnaire and you have reviewed the pertinent or key finding(s) with the patient and/or family. Key finding(s) must be summarized in your progress note, however the questionnaire may be referenced for additional details.

DATE TIME	ATTENDING PHYSICIAN SIGNATURE:
	PRINT NAME: PAGER: