CHILD'S NAME *(Last, First)* ______________________________ DOB ____________ SEX  M  F DATE OF VISIT ____________

# **Pediatric Weight Management** Medical Summary: Assessment

## VITAL SIGN (BASELINES)

HT ________ in/cm ________ % WT ________ LB/KG ________ % BMI ________ kg/m^2 BMI% ________

BLOOD PRESSURE ________ / ________ mmHg ________ % PULSE ________ BPM ________ OTHER ________

## RELEVANT FINDINGS

| | |
|---|---|
| **Patient History** (Diet, Physical Activity) | |
| **Symptoms** | |
| **Physical Exam** | |
| **Lab(s)*** | |

** Attached most recent relevant labs (e.g. total cholesterol mg/dl; LDL calculated and direct mg/dl, HDL C mg/dl; triglycerides mg/dl; ALT; fasting glucose):*

## DIAGNOSES AND CO-MORBIDITIES

- Abnormal lipids
- Acanthosis nigricans
- Asthma
- Disordered Eating
  *(e.g. binge eating, food-seeking behavior, etc.)*
- GERD
- Elevated blood pressure; hypertension not diagnosed
- Hypertension
- Mental Illness (e.g. Depression, Anxiety)
- Other:
- Metabolic syndrome
- Elevated liver enzymes
- NASLD or NASH
- Orthopedic issues/joint/bone problems
- Abnormal Menses
- Polycystic ovarian syndrome
- Pre-diabetes
- Snoring
- Sleep Apnea

## BEHAVIORAL ASSESSMENT

Did you discuss readiness and confidence to change with the patient and/or parent/caregiver?  Y  N

RESULTS ________________________________________

PCP PERCEPTION ________________________________________

Was a target behavior identified (only for engaged/ready patients)?  Y  N If so, what:

________________________________________

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CHILD'S NAME *(Last, First)* ______________________ DOB ____________ SEX ☐ M ☐ F DATE OF VISIT ____________

# Pediatric Weight Management Medical Summary: Family Strengths & Additional Information

**FAMILY INFORMATION** *(Who is at home, who cares for child, circumstances such as financial or emotional stresses):*

Caregivers ____________________________________________

Siblings ____________________________________________

Other important facts ____________________________________________

**CHILD'S STRENGTHS** *(e.g. personality traits, current extracurricular activities, hobbies)*

**SPECIAL CIRCUMSTANCES/OTHER COMMENTS**

PHYSICIAN/PROVIDER SIGNATURE ____________________________________________

PRINT NAME ABOVE ______________________ DATE OF VISIT ______________________

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American Academy of Pediatrics Institute for Healthy Childhood Weight

CHILD'S NAME *(Last, First)* ______________________ DOB ______________ SEX ☐ M ☐ F DATE OF VISIT ______________

# Pediatric Weight Management Medical Summary: Prevention Plus/Structured Weight Management

## INITIAL VISIT

NICKNAME ______________________ EMAIL ______________________

PARENT (CAREGIVER) ______________________ RELATIONSHIP ______________________

ADDRESS ______________________________________________

PHONE ______________ BEST TIME ______________ ALT PHONE ______________

OTHER PARENT (CAREGIVER) ______________________ PHONE ______________________

EMERGENCY CONTACT/RELATIONSHIP ______________________ PHONE ______________________

OTHER EMERGENCY CONTACT ______________________ PHONE ______________________

HEALTH INSURANCE PLAN ______________________ IDENTIFICATION # ______________________

ALLERGIES/REACTION ______________________________________________

______________________________________________

CURRENT MEDICATIONS/DOSE AND SUPPLEMENTS/OTC/HERBS/VITAMINS ______________________

______________________________________________

PRIOR SURGERIES/PROCEDURES

______________ Date ______________ ______________ Date ______________

______________ Date ______________ ______________ Date ______________

HISTORY OF PRIOR ILLNESS/MEDICAL HISTORY ______________________

______________________________________________

MOST RELEVANT LAB FINDINGS

______________ Date ______________ ______________ Date ______________

______________ Date ______________ ______________ Date ______________

PHYSICAL LIMITATIONS ______________________________________________

______________________________________________

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CHILD'S NAME *(Last, First)* ______________________ DOB __________ SEX ☐ M ☐ F DATE OF VISIT __________

## INITIAL VISIT (CONTINUED)

PRIMARY CARE PROVIDER ______________________ CLINIC/HOSPITAL ______________________

PHONE __________ OTHER *(fax, email, etc.)* ______________________

OTHER RELEVANT PROVIDERS ______________________ CLINIC/HOSPITAL ______________________

PHONE __________ OTHER *(fax, email, etc.)* ______________________

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