Pediatric Obesity Medicine and Nutrition

Initial Visit Questionnaire

Patient Name: _____ Date of Birth: _____

1. Does your child have any medical problems or diagnoses?

   _____

2. Does your child take any medicine, vitamins or supplements?

   _____

3. Does your child have any family members (parents, siblings, grandparents) with:
   a. High blood pressure or hypertension ☐ Y ☐ N ☐ Don't know
   b. Stroke ☐ Y ☐ N ☐ Don't know
   c. High cholesterol ☐ Y ☐ N ☐ Don't know
   d. Heart attack ☐ Y ☐ N ☐ Don't know
   e. Diabetes ☐ Y ☐ N ☐ Don't know
4. Has your child ever had surgery?

   _____

5. Does your child have any allergies to medicines or foods?

   _____

6. Has your child ever taken steroids? If so, when?

   _____

Please answer the following questions to the best of your knowledge. If you don't know, please write 'unknown'

7. How much did your child weigh at birth? _____
8. Was your child early, late or on time at birth? _____
9. Was your child breast fed, formula fed or both? _____
10. Did mother have any problems with blood pressure or blood sugar at birth?

    _____

11. How was your child delivered? C section or vaginal (natural)

    _____

12. Does your child ever watch videos of people eating (for example Mukbang)?

    _____

Please circle the answer for any recent symptoms listed:

Fatigue or feeling tired all the time	☐ yes	☐ no	☐ don't know
Blurry vision	☐ yes	☐ no	☐ don't know
Snoring	☐ yes	☐ no	☐ don't know
Chest pain	☐ yes	☐ no	☐ don't know
Stomach pain	☐ yes	☐ no	☐ don't know

Constipation	☐ yes	☐ no	☐ don’t know
Frequent urination	☐ yes	☐ no	☐ don’t know
Excessive thirst	☐ yes	☐ no	☐ don’t know
Headaches	☐ yes	☐ no	☐ don’t know
Leg or back pain	☐ yes	☐ no	☐ don’t know
Leg or foot swelling	☐ yes	☐ no	☐ don’t know

Submit

Initial Visit Diet Questionnaire

Does your child have any food allergies? Yes No If yes, please list _____

Does your child experience any of the following?

- ☐ Nausea or Vomiting
- ☐ Problems chewing or swallowing foods
- ☐ Abdominal pain after eating
- ☐ Diarrhea
- ☐ Constipation
- ☐ None

Please check all foods your child is willing to eat:

Snacks	Meats/Proteins	Vegetables and Fruit		
☐ Chips/pretzel	☐ Chicken nuggets	☐ Broccoli	☐ Beans	
☐ Candy	☐ Baked/grilled chicken	☐ Cauliflower	☐ Peas	☐ Apples
☐ Cookies	☐ Pork chops/loin	☐ Corn	☐ Potatoes	☐ Oranges
☐ Snack Cakes	☐ Fried Chicken	☐ Greens	☐ Lettuce	☐ Berries
☐ Crackers	☐ Fried fish	☐ Carrots	☐ Tomatoes	☐ Melon
☐ Yogurt	☐ Baked fish or tuna	☐ Cucumber	☐ Squash	☐ Grapes
☐ Cheese sticks	☐ Beef (steaks, roast)	☐ Green beans	☐ Zucchini	☐ Banana
☐ Nuts	☐ Eggs	☐ Bell pepper	☐ Asparagus	
	☐ Other_____			

Please list all foods and beverages consumed yesterday at each meal and snack.

Breakfast (or first meal of the day): _____

Morning snack: _____

Lunch: _____

Afternoon Snack: _____

Dinner: _____

After Dinner Snack: _____

Beverages:

- ☐ Water (plain)
- ☐ Regular Soda
- ☐ Diet Soda
- ☐ Milk (white)
- ☐ Juice
- ☐ Gatorade
- ☐ Koolaid
- ☐ Coffee (frap or latte)
- ☐ Sweet Tea
- ☐ Lemonade
- ☐ Sugar-Free Packets (koolaid or crystal light)

How often do you dine out or eat fast food? _____ times per week

Where do you typically go? _____

What topic(s) are you most interested in learning about today?

- ☐ Healthy Eating
- ☐ Snacks
- ☐ Beverages
- ☐ Introducing new foods
- ☐ Help with cholesterol or blood sugars
- ☐ Carb needs for your child
- ☐ Healthy cooking methods
- ☐ Other: _____