GI For Kids

Pediatric Gastroenterology and Nutrition Services
Excellent Care Every Time
1975 Town Center Blvd · Knoxville, TN 37922
Phone (865) 546-3998 · Fax (865) 546-1123 · www.giforkids.com

Healthy Lifestyle Program - New Patient Medical History Form

Name: (First)________________________________ (Last) ________________________________ (MI)____
Date of Birth: _____/_____/__________ Date of Visit: _____/_____/__________
Phone: (Home/Cell)________________________ (Work) ________________________

Sex: ☐ Male ☐ Female ☐ Transgender Male (F to M) ☐ Transgender Female (M to F) ☐ Decline

Referred By: ________________________________

How does weight affect your child's life and health?
____
____

Weight History

When did you first notice that your child was gaining weight?
☐ Infancy ☐ Childhood ☐ Adolescence ☐ Adulthood ☐ Pregnancy

Did your child ever gain more than 20 pounds in less than 3 months? Y / N
If so, when? _________

How much did your child weigh: One year ago? _____ Five years ago? _____ Ten years ago? _____

What was your child's maximum weight? _______

Life events associated with weight gain (check all that apply):

o Marriage of a parent o Divorce of a parent o Pregnancy o Abuse o Illness o Death of a parent/relative o Travel o Injury
o Job change in household o Quitting smoking o Alcohol
o Change of school o Other chronic stress
o Medication (please list): ____

What were your child's perceived weight change triggers: ______________________________________
____

What changes have you already tried to make? (check all that apply): __________________________
o Commercial weight loss program o Specific Diet (Keto, Atkins, Low-carb, Mediterranean diet, Paleo)o Seen a dietician o Other:

What are your greatest challenges with your child's weight?
____

Medication History

Has your child ever taken medication to lose weight? (check all that apply):

☐ Phentermine (Adipex) ☐ Meridia ☐ Xenecal/Alli ☐ Metformin
☐ Contrave ☐ Topamax ☐ Saxenda ☐ Victoza
☐ Bupropion (Wellbutrin) ☐ Ozempic ☐Trulicity ☐ Qsymia

Other (including supplements): ____

What worked? ____
What didn't work? ____
Why or why not? ____

Medications (list all current medications, including over-the-counter medications, supplements, and herbs):

_____________________ _____________________ _____________________ _____________________
_____________________ _____________________ _____________________ _____________________

Nutritional History

How often does your child eat breakfast? _____ days per week at _____:_____ a.m.
Number of times your child eats per day: _____ What beverages do they drink? _____________________
Do you get up at night to eat? Y / N If so, how often? _____ times

List any food intolerances/restrictions: ____

Food triggers (check all that apply):

☐ Stress ☐ Boredom ☐ Anger ☐ Insomnia ☐ Seeking reward
☐ Parties ☐ Eating out ☐ Other: ________________________

Food cravings:

☐ Sugar ☐ Chocolate ☐ Starches ☐ Salty ☐ Fast food
☐ High fat ☐ Large portions

Favorite foods: ____

Behavior

Does your child display "out of control" behavior towards eating? (Such as eating too much, "hungry" all the time, sneaking food) ☐ Yes ☐ No

Do you need help with establishing boundaries for food/eating? ☐ Yes ☐ No

Do you think your child eats due to sadness, boredom and/or loneliness? ☐ Yes ☐ No

Has your child or your family experienced recent trauma or stress that you feel may be contributing to current health concerns? ☐ Yes ☐ No

Describe:____
____

Has there ever been a diagnosis of an eating disorder? ☐ Yes ☐ No
If yes, which one? ____

Food insecurity

Within the past 12 months, we were worried whether our food would run out before we got money to buy more?
☐ Yes ☐ No

Within the past 12 months, the food we bought just didn't last and we didn't have money to get more?
☐ Yes ☐ No

Medical History

Past medical history (check all that apply):
☐ Gallbladder stones ☐ Indigestion/reflux ☐ Thyroid disease ☐ Diabetes
☐ High blood pressure ☐ High cholesterol ☐ Celiac disease ☐ Anxiety
☐ High triglycerides ☐ Pancreatitis ☐ Depression ☐ Bullying
☐ ADHD ☐ Bipolar ☐ Polycystic ovarian syndrome
☐ Arthritis ☐ Other: ____

Past surgical history (check all that apply):
☐ Gastric bypass ☐ Gastric banding ☐ Gastric sleeve ☐ Gallbladder
☐ Other: ____

Allergies: (Medications)____
(Food)____

Sleep History

How many hours does your child sleep per night? ___________________

Does your child feel rested in the morning? ☐ Yes ☐ No

Please indicate if your child has any of the following:
☐ Snoring ☐ Pauses in breathing ☐ Waking with dry throat
☐ Daytime sleepiness ☐ Sleep apnea/disordered eating ☐ Nocturnal enuresis ☐ Night eating

Physical Activity History

Describe the type of physical activity your child engages in:
____
Duration: _____ hours _____ minutes Number of times per week: _____

Does anything limit your child from being physically active? ____
____

Social History
Smoking: ☐ N/A ☐ Never ☐ Current smoker (___packs/day)
☐ Past smoker (quit _____ years ago) ☐ Vaping

Alcohol: ☐ N/A ☐ Never ☐ Occasional ☐ Regularly (_____ drinks per day)

Drugs: ☐ N/A ☐ Never ☐ Current ☐ Past ☐ Type of drugs: ___________

Marijuana: ☐ N/A ☐ Never ☐ Current user (_____ times/day)

Family History (Check all that apply)

Obesity: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Grandmother ☐ Grandfather
Diabetes: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Grandmother ☐ Grandfather
Other:
☐ High blood pressure ☐ Heart disease ☐ High cholesterol ☐ Asthma ☐ ADHD
☐ High triglycerides ☐ Stroke ☐ Thyroid problems ☐ Anxiety ☐ Depression
☐ Bipolar disorder ☐ Alcoholism ☐ Liver disease ☐ Sleep disorder ☐ Pancreatitis
☐ Cancer (type/s): ____ Other: ________________________

Gynecologic History (Female)

Menstrual periods are: ☐ Not Started Age menstrual periods began: _________
☐Regular ☐Irregular ☐Heavy ☐Normal ☐Light ☐Absent
History of Pregnancy: ☐ Yes ☐ No ☐ N/A

System Review (Check all that apply)

General:
☐ Recent weight loss ☐ Recent weight gain ☐ Increased appetite ☐ Decreased appetite

Respiratory:
☐ Cough ☐ Snoring ☐ Shortness of breath

Cardiovascular:
☐ Chest pain ☐ Fainting ☐ Swelling ankles/extremities ☐ Palpitations

Gastrointestinal:
☐ Abdominal pain ☐ Bloating ☐ Constipation ☐Diarrhea ☐ Food intolerance
☐ Indigestion ☐ Heartburn ☐ Nausea/vomiting ☐ Gas and bloating ☐ Blood in stools
☐ Dysphagia/difficulty swallowing

Genitourinary:
☐ Urinary frequency/urgency ☐ Nighttime urination

Musculoskeletal:
☐ Back pain (upper) ☐ Back pain (lower) ☐ Muscle aches/pain ☐ Joint pain

Integumentary:
☐ Acne ☐ Rash ☐ Skin breakdown

Neurological:
☐ Dizziness ☐ Headaches ☐ Weakness/low energy ☐ Seizures ☐ Fainting/Syncopal episodes

Psychiatric:
☐ Anxiety ☐ Depression ☐ Insomnia ☐ Hyperactivity ☐ Inability to concentrate ☐ Nervousness
☐ Inattention ☐ Mood changes

Endocrine:
☐ Excessive thirst ☐ Cold intolerance ☐ Excessive sweating ☐ Hair changes ☐ Heat intolerance

Immunologic:
☐ Fatigue/tiredness ☐ Bruising

GI For Kids

Pediatric Gastroenterology and Nutrition Services
Excellent Care Every Time
1975 Town Center Blvd · Knoxville, TN 37922
Phone (865) 546-3998 · Fax (865) 546-1123 · www.giforkids.com

Healthy Lifestyle Program - Physical Activity Survey

Name: ______________________________________ **Date of Birth:** _______________ **Age:** _____

How many hours per day do you spend watching TV, playing video games and/or using a computer?
Weekdays: ______________ Weekends: ______________

How often (outside of school gym class) are you so active playing, exercising, or doing sports (that your heart beats fast and you breath hard for 20 minutes or more at a time)?
☐ Everyday ☐ 5-6 days a week ☐ 3-4 days a week ☐ 1-2 days a week ☐ Less than 1 day a week

What activities do you generally participate in at school and outside of school? (sports, classes, and/or play)?

Activity:	At school	Outside of school
__________________________	☐	☐
__________________________	☐	☐
__________________________	☐	☐
__________________________	☐	☐

Which of the following items do you have in your home, yard, or apartment complex? Check all that apply.

☐ Bike
☐ Dog
☐ Trampoline
☐ Running shoes/sneakers
☐ Weight lifting equipment
☐ Skis (snow or water)
☐ Step or slide aerobic
☐ Swimming pool
☐ Ice skates
☐ Roller blades/skates
☐ Sports equipment (balls, racquets, etc.)
☐ Workout videos or audio tapes
☐ Swimming or scuba equipment
☐ Treadmill or other exercise equipment
☐ Skis (snow or water)
☐ Other: ____

Do any of the following prevent you from exercising? Check all that apply

☐ Lack of interest in physical activities
☐ Lack of self discipline
☐ Lack of time
☐ I don't like sweat
☐ I don't have anyone to do physical activity with me
☐ Lack of knowledge of how to do physical activities
☐ I don't have an easy place to do physical activity
☐ I am chosen last for teams
☐ Physical activity messes up my appearance
☐ Lack of energy
☐ Lack of skills
☐ Homework
☐ Lack of equipment
☐ I don't enjoy physical activity
☐ My friends don't like exercise
☐ Self conscious about my looks when I do activities
☐ My friends tease me during exercise or sports
☐ I don't want to get stronger/muscular
☐ I am too heavy
☐ The weather is too hot, cold, rainy
☐ I am too tired to exercise
☐ Physical activity is boring
☐ Other: ____

Please check off any of the following that getting the way of you being physically active:
☐ At home there aren't enough supplies or sports equipment to use (like balls, basketball hoops, bicycles, skates, etc.)
☐ There are no playgrounds, parks, or gyms close to where I live that I can easily get to
☐ It is not safe to walk, bike, run in my neighborhood
☐ It is difficult to walk, bike, or run in my neighborhood because of traffic, no sidewalk, no bike lanes, dogs, and so on.
☐ Other: ____

GI For Kids

Pediatric Gastroenterology and Nutrition Services
Excellent Care Every Time
1975 Town Center Blvd · Knoxville, TN 37922
Phone (865) 546-3998 · Fax (865) 546-1123 · www.giforkids.com

Healthy Lifestyle Program - Health Check-In: Initial

Patient Name: ___________________________ **Date of Birth**: ________________ **Date:**______________

Question	Answer	Comment
1. How many servings of fruits and/or vegetables are recommended every day?		
1b. How many servings do you have most days?		
2. What is the recommended daily limit for recreational screen time (in hours)? [*screen time includes use of TV, phone, game console, computer, etc. not related to schoolwork]*		
2b. How many hours of screen time do you have every day?		
3. How much time is recommended for being active every day (in hours)?		
3b. How much do you get?		
4. How many sweetened drinks such as soda or Gatorade is recommended every day?		
4b. How many do you have?		

On a scale of 1 to 10, with 1 being very untrue and 10 being very true, rate each statement below.

5. I feel ready to improve my eating habits.	
6. I feel ready to improve my physical activity.	
7. I feel I have worked on healthy habits	
8. I feel my current fitness level is in the healthy range.	

Please answer the following questions below.

9. What do you and your family hope to learn when attending the Healthy Lifestyle Clinic?

10. What changes have you already worked on to improve your health, prior to coming to this clinic?

11. Please share any other successes or challenges that can help our team meet your needs.