CURRENT PATIENT MEDICAL HISTORY FORM-Peds

Introduction: We will use this information to take care of your child. We will keep records of each visit so that we can provide the best possible care. All information we keep is confidential and accessible only to us.

Name: (First)_____ (Last) _____ (MI)____ Date of Birth: ____/_____/_____
Name prefer to be Called:_____
Referred By: _____

Date of Visit: ____/_____/_____

School Status Information:

Name of School/College:_____ Grade in school/college:_____
School District:_____ School Assistance/IEP/504 Plan:_____
Home School:_____

Preferred Pharmacy:_____ City:_____ State:_____
Phone Number: (____)_____

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

Weight History:

When did you first notice that your child was gaining weight?
o Infancy o Childhood o Adolescence
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?
_____

M**edication History:**

Has your child ever taken medication to lose weight? (check all that apply):
o Phentermine (Adipex) o Meridia o Xenecal/Alli o Metformin
o Contrave o Topamax o Saxenda o Victoza
o Bupropion (Wellbutrin) o Ozempic oTrulicity o Qsymia
Other (including supplements): _____
What worked? _____
What didn't work? _____
Why or why not? _____

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):
o Stress o Boredom o Anger o Insomnia o Seeking reward
o Parties o Eating out o Other: _____

Food cravings:
o Sugar o Chocolate o Starches o Salty o Fast food
o High fat o Large portions
Favorite foods: _____

Behavior:

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

Do you need help with establishing boundaries for food/eating?

o Yes o No

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

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

Has there ever been a diagnosis of an eating disorder? o Yes o 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?

o Yes o No

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

Sleep History:

How many hours does your child sleep per night?
Does your child feel rested in the morning? o Yes o No
Please indicate if your child has any of the following:
o Snoring o Pauses in breathing o Waking with dry throat
o Daytime sleepiness o Sleep apnea/disordered eating o Nocturnal enuresis (bed wetting) o 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: o N/A o Never o Current smoker (___packs/day)
o Past smoker (quit _____ years ago) o Vaping

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

Drugs: o N/A o Never o Current o Past o Type of drugs: _____

Marijuana: o N/A

o Never o Current user (_____ times/day)

Gynecologic History (Female):

Menstrual periods are: o Not Started
oRegular oIrregular
oHeavy oNormal oLight
oAbsent
Age menstrual periods began: _____ o N/A
History of Pregnancy: o Yes o No o N/A

System Review (Check all that apply):

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

Respiratory:
o Cough o Snoring o Shortness of breath

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

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

Genitourinary:
o Urinary frequency/urgency o Nighttime urination

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

Integumentary:
o Acne o Rash o Skin breakdown

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

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

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

Immunologic:

o Fatigue/tiredness

o Bruising

Comments:

_____

Financial Policy:

Thank you for selecting Peacock Pediatrics for your child's healthcare needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy.

Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. We accept some forms of insurance. Please discuss your insurance coverage with a staff member.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection cost, attorney's fees, and court cost.

I have read and understand all of the above and agree to these statements.

_____
Patient Signature

_____
_____
Signature of parent/guardian if child is under the age of 18 Date
(or signature of person with authority to consent for patient)

_____
Printed name of parent/guardian

Peacock Pediatrics Obesity Program Consent Form

I, _____, authorize Peacock Pediatrics to help my child improve their health. I understand that my child's program may consist of a diet, increase in physical activity, instruction on behavior modification, and possibly the use of anti-obesity medications.

I understand that if the use of anti-obesity medications is agreed to be a part of the treatment plan, then the specific advantages and disadvantages of each medication will be discussed thoroughly.

I understand that much of the success of the program will depend upon my child's responses to the treatment plan. I also understand that obesity is a chronic, lifelong condition that will require sustained treatment and adjustments in eating habits, activity level, and behavior to be effective.

I have read and full understand this consent form and it has been fully explained to me. My questions have been answered to my complete satisfaction.

_____
Patients Name (Printed)

_____
Patient's Signature

_____ _____
Signature of parent/guardian if child is under the age of 18 Date
(or signature of person with authority to consent for patient)

_____
Printed name of parent/guardian if child is under the age of 18

Weight Management Group Visits Consent

Our team will form groups of 5-7 patients with similar backgrounds to be seen as a group. These visits will take place on Microsoft Teams, and Dr. Ford will have individual time with each patient. These visits will be billed as follow-up visits and all applicable co-pays will apply.

I understand that the group visits are designed to provide education, support, and guidance for weight management through discussions, activities, and shared experiences within a group setting.

Benefits of Participation: Participating in group visits can offer benefits such as increased motivation, shared learning, peer support, and access to additional resources for managing weight.

Nature of Group Visits: The group visits will involve discussions on topics related to nutrition, physical activity, behavioral strategies, and emotional wellness aimed at achieving and maintaining a healthy weight.

Confidentiality: I understand that information shared within the group will be kept confidential within the bounds of group participation and will not be disclosed outside of the group without my consent.

Voluntary Participation: My participation in the group visits is voluntary, and I understand that I can withdraw from the group at any time without penalty or affecting my medical care.

Risk and Discomfort: I understand that while participating in group discussions, I may experience emotional or personal discomfort. The facilitators will work to maintain a supportive and respectful environment.

Use of Information: I agree that information gathered during the group visits, including my participation and progress, may be used for research or educational purposes, but my identity will be kept confidential.

Responsibilities: I understand that it is my responsibility to actively participate in the group visits, follow the guidelines provided, and inform the facilitators of any concerns or questions I may have.

Emergency Contact: I will provide emergency contact information to the group facilitators in case of any medical or personal emergencies during the group visits.

Agreement: I have read and understand the nature and purpose of the group visits for weight management. By signing below, I agree to participate in these group visits voluntarily.

Patient Name:

_____ Patient Signature:_____ Date:

_____

Signature of parent/guardian if child is under the age of 18:_____

Printed name of parent/guardian:_____

Date:_____