Peacock Pediatrics

An Affiliate of Children's Mercy

PROUDLY PROVIDING PERSONALIZED CARE FOR CHILDREN OF EVERY AGE AND EVERY STAGE

NEW PATIENT MEDICAL HISTORY FORM- Adult

Name: (First)_____ (Last) _____ (MI)____ Date of Birth: ____/_____/_____
Name prefer to be Called:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone: (Home/Cell)_____ (Work) _____
E-Mail Address:_____
Sex: Male Female Transgender (F to M) Transgender (M to F)
Marital Status: Single Married Domestic Partnership Divorced Separated Widowed
Employment Status: Full Time Part-time Unemployed Disabled Retired Military

Referred By: _____

Date of Visit: ____/_____/_____

Emergency Contact (1):
Name: _____ Relationship: _____ Phone: (____)_____

Emergency Contact (2):

Name: _____ Relationship: _____ Phone: (____)_____

Primary Care Provider: _____ Practice Name: _____ Phone: (___)_____

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

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

How does weight affect your life and health?
_____
_____
_____
_____

Weight History:

When did you first notice that you were gaining weight?
Childhood Teens Adulthood Pregnancy Menopause
Did you ever gain more than 20 pounds in less than 3 months? Y / N
If so, when? _____
How much did you weigh: One year ago? _____ Five years ago? _____ Ten years ago? _____
What was your child's maximum weight?

Life events associated with weight gain (circle all that apply):
Marriage Divorce Pregnancy Abuse Illness Death of a parent/relative Travel Injury

Job change Quitting smoking Alcohol Drugs Nightshift Work Other chronic stress
Medication (please list): _____

Previous Weight-loss programs (circle all that apply)

Weight Watchers	Nutrisystem	Jenny Craig	Dash Diet
South Beach	Zone Diet	Medifast	Atkins
HCG Diet	Mediterranean Diet	LA Weight Loss	Paleo Diet

Other:_____

What was your maximum weight loss?
_____
_____
_____

What are your greatest challenges with dieting?
_____
_____
_____

Medication History:

Have you ever taken medication to lose weight? (circle all that apply):
Phentermine (Adipex) Meridia Xenecal/Alli Phen/Fen Phendimetrazine (Bontril)
Contrave Topamax Saxenda Victoza Bupropion (Wellbutrin) Ozempic 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 you eat breakfast? _____ days per week at _____:_____ a.m.
Number of times you eats per day: _____ What beverages do you drink? _____
Do you get up at night to eat? Y / N If so, how often? _____ times
List any food intolerances/restrictions: _____

Food triggers (circle 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: _____

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

Medical History:
Past medical history (circle all that apply):
Gallbladder stones Indigestion/reflux Thyroid disease Diabetes High blood pressure High cholesterol Celiac disease Anxiety High triglycerides Pancreatitis Depression Stroke ADHD Bipolar Polycystic ovarian syndrome Arthritis Infertility Gout Gallstones Angina Glaucoma Cancer:_____ Other:_____

Past surgical history (circle all that apply):
Gastric bypass Gastric banding Gastric sleeve Gallbladder Heart Bypass Hysterectomy
Other:_____

Allergies:
(Medications)_____
(Food)_____

Sleep History:

How many hours do you sleep per night? _____
Do you feel rested in the morning? o Yes o No
Please indicate if you have 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 you engage in:
_____
Duration: _____ hours _____ minutes Number of times per week: _____
Does anything limit you from being physically active? _____

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

Alcohol: Never Occasional Regularly (_____ drinks per day)
Previous Treatment for alcoholism? Y/N

Drugs: Never Current Past Type of drugs: _____

Marijuana: Never Current user (_____ times/day)

Family History:

Obesity (circle all that apply): Mother Father Sister Brother Grandmother Grandfather

Diabetes (circle all that apply): Mother Father Sister Brother Grandmother Grandfather

Other (check all that apply): High blood pressure Heart disease High cholesterol High triglycerides Stroke Thyroid problems Anxiety Depression Bipolar disorder Alcoholism Liver disease Sleep disorder Pancreatitis Asthma ADHD

Cancer (type/s): _____ Other: _____

Gynecologic History (Female):

Menstrual periods are:

Regular Irregular

Heavy Normal Light Absent

Age menstrual periods began: _____

History of Pregnancy: Yes No

Number of Pregnancies:_____ Number of Children:_____ Age of first pregnancy:_____ Age of last pregnancy:_____

System Review (Circle all that apply):

General:

Recent weight loss more than 10 LBS Recent weight gain more than 10LBS Increased appetite Decreased appetite

Respiratory:

Cough Snoring Shortness of breath

Cardiovascular:

Chest pain Fainting Swelling ankles/extremities Palpitations

Gastrointestinal:

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

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 Mood changes Inattention

Endocrine:

Excessive thirst Cold intolerance Excessive sweating Hair changes Heat intolerance

Immunologic:

Fatigue/tiredness Bruising

Females Only:

Absence of periods Hot flashes change in bladder habits abnormal/excessive menstruation facial hair

Comments:

_____

__

Insurance:

Primary Insurance:_____
Secondary Insurance:_____
Please present your insurance cared to staff at the front desk.

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

Patient Name (Printed)

_____

Date

CONSENT FOR USE OF

ANTI-OBESITY MEDICATIONS

NOTE: SIGNING THIS FORM DOES NOT GUARANTEE THAT YOUR PROVIDER(S) AT PEACOCK PEDIATRICS WILL FIND YOU TO BE AN APPROPRIATE CANDIDATE FOR ANTI-OBESITY MEDICATIONS, BUT ONLY THAT YOU HAVE READ, UNDERSTOOD, AND AGREE TO THE TERMS OF MEDICATION USAGE SHOULD YOU AND DR. FORD DECIDE UPON THEIR USAGE NOW OR IN THE FUTURE.

Some anti-obesity medications are considered "controlled medications." By law, a controlled medication can only be prescribed from one facility at a time; therefore I agree that only Peacock Pediatrics will prescribe anti-obesity medications for me. I agree that it is my responsibility to inform my provider(s) at Peacock Pediatrics and any other providers from whom I receive treatment of all medications prescribed to me. **I understand that the use of anti-obesity medications is contraindicated with certain medical histories, allergies, or other medication use**. I agree that I will be honest in disclosing this information and will notify my provider(s) at Peacock Pediatrics of any changes to my medical history or medication usage. I understand that failure to do so can be dangerous to my health.

I agree to take the medication only as prescribed and directed by Dr. Ford. I understand that taking medications in any way other than as directed and prescribed could affect my health and be dangerous.

I understand that the use of some of the anti-obesity medications beyond 12 weeks is considered "off label" or not initially approved by the U.S. Food and Drug Administration (FDA). I understand that my provider(s) at Peacock Pediatrics are experienced specialist(s) in obesity medicine who will, at times, elect or choose, when indicated, to use the anti-obesity medication(s) for longer periods of time as deemed appropriate for my individual treatment.

I understand that I am to report any side effects or adverse reactions of my medications to my provider(s) at Peacock Pediatrics.

I understand that it is my responsibility to follow the instructions carefully and that the purpose of this treatment is to assist me in my desire to decrease my body weight for improvement of health and to maintain weight loss. I understand that the purpose of medications for weight loss is to be used as an adjunct to a program that includes nutrition and/or physical activity and/or behavior modification.

I understand that much of the success of the program will depend on my efforts and that there are **NO GUARANTEES** in medical treatment of the disease of obesity. I also understand that I will have to continue monitoring my weight after active weight loss.

Patient Signature: _____ Date: _____

Patient Name (printed): _____

Why I Want to Lose Weight…

Before you begin your weight loss journey, it is important to spend time reflecting on why YOU want to lose weight. Make sure that that these are personal motivators and are not intended to please others. Reviewing this list frequently will help keep you on track and focused on your personal commitment to take control of your health!

Please list five reasons you want to lose weight:

1._____

2._____

3._____

4._____

5._____

Describe the physical benefits you hope to get by losing weight:

_____

_____

_____

Describe the functional benefits you hope to get by losing weight:

_____

_____

Describe the medical benefits you hope to get by losing weight:

_____

_____

Describe the psychological benefits you hope to get by losing weight:

_____

_____

How I Plan to Lose Weight…

Goal setting is the "how" of weight loss. Motivators are the "why." When setting goals, utilize the SMART technique:

SMART	Technique	Example
Specific	Who, what, where, when, how…	"I want to lose 10 pounds in two months."
Measureable	How will you track?	10 pounds in 8 weeks = 1.25 pounds/week
Attainable	Resources you have available, previous experience	"I have been able to do this before, and now I have new tools from my doctor!"
Relevant	Why this goal is important	Review your motivators
Timely	Set benchmarks and deadlines	"Focusing for two month intervals works for me."

Please list three goals you would like to achieve during your treatment:

1._____

2._____

3._____