STONY BROOK UNIVERSITY MEDICAL CENTER

Healthy Weight and Wellness Center
Pediatric Gastroenterology

Medical Information Questionnaire **Today's Date:** _____

Name: _____ Date of Birth: ____/____/____

Home phone: _____ Cell phone: _____ Email: _____

Parent(s) Name: _____

Insurance provider: _____ Insurance ID: _____

Primary care provider: _____ Pharmacy phone: _____

Therapist (if working with one): _____

Past Medical History:

Any prior illnesses, hospitalizations, or surgeries? _____

Birth: ☐ Full-term ☐ Pre-term _____ weeks ☐ NICU _____ weeks Birthweight: _____

Current medications: Please list _____

Allergies (medications, foods, environmental): _____

Family History:

Patient's mother: Age ___ Medical problems _____

Patient's father: Age ____ Medical problems _____

Siblings: Age ____ Medical problems _____

Age ____ Medical problems _____

Other Siblings:

_____

Social History:

Does patient attend school? _____ Grade _____ Any problems in school? _____

Who lives in the home? _____ Primary caretaker _____

Mother's occupation _____ Father's occupation _____

Systems Review: Please check any of the following issues that have occurred over the past 6 months

☐ Fever ☐ Weight loss ☐ Fatigue ☐ Repeated infections ☐ Rashes	☐ None
☐ Double vision ☐ Blurred vision ☐ Red eye ☐ Glaucoma	☐ None
☐ Shortness of Breath ☐ Wheezing ☐ Cough with Exercise ☐ Passing out ☐ Turning blue	☐ None
☐ Chest pain ☐ Palpitations ☐ High blood pressure	☐ None
☐ Stomach pain ☐ Heartburn ☐ Constipation ☐ Diarrhea ☐ Food getting stuck ☐ Nausea/Vomiting ☐ Stool leaking ☐ Blood/mucus in stool	☐ None
☐ Kidney problems ☐ Kidney stones ☐ Enuresis ☐ High blood pressure	☐ None
☐ Joint problems ☐ Joint swelling	☐ None
☐ Depression ☐ Anxiety ☐ ADD/ADHD ☐ School performance issues ☐ Behavioral issues ☐ Poor body image	☐ None
☐ Thyroid disease ☐ Diabetes ☐ PCOS ☐ Dark patches on neck/ under arms/breasts/waist/groin ☐ New hair on face/lips/chest/abdomen ☐ Hair loss/balding	☐ None
☐ Weakness ☐ Headache ☐ Seizure	☐ None
☐ Bleeding ☐ Bruising ☐ Anemia	☐ None
☐ Difficult sleeping ☐ interrupted sleep ☐ Tired all the time ☐ Snoring ☐ Falls asleep a lot during the day ☐ Sleeps upright	☐ None
☐ Picky eater ☐ Avoids certain textures ☐ Food allergies ☐ Food intolerance	☐ None
☐ Other (please write here)	

Weight: Parent to fill out
At what age did your child's weight become a concern? _____ years of age
Did your child's weight change as a result of the covid-19 pandemic? _____
What have you tried to help your child lose weight? Please list:
_____
_____

Do you or other family members struggle with their weight? YES/NO Who? _____
Have any family members had bariatric surgery for weight loss? YES/NO Who? _____
Are any family members taking medication to assist with weight loss? YES/NO Who?_____

Physical Activity: : Child/Parent to fill out (if appropriate)
Do you enjoy physical activity? YES/NO Is your family physically active? YES/NO
Do you participate in any organized school or community sports/activities? YES/NO _____
How many times and for how long do you exercise per week? _____ x week; _____ minutes each time
What is a barrier that prevents you from exercising? _____

Sleeping Habits/ Screen Time : Child/Parent to fill out (if appropriate)
Go to bed _____ AM/PM Wake up _____ AM/PM Do you Nap? YES/NO
How many hours per day (outside of school) do you spend on a screen (TV/Laptop/Video games/Cellphone): _____ hours

Nutrition: Child/Parent to fill out
Please circle all that apply to you or your families eating habits.

I skip meals	I eat fruits and vegetables at least 2 x per day
I drink sugary beverages at least 1 x per day	I have fast food a few times per week
I eat when I am bored/happy/sad/stressed	I sometimes feel out of control when I eat
I am never sure when I am full	Others have said that I snack too much
I sneak foods	My family will use food as a reward
I eat when I am sad/depressed	I eat in front of the TV or computer at least 1 x day
I love sweets and can't stay away from them	I have experienced bullying about my weight

What HABITS/BEHAVIORS are you interested in changing now? (please check off)

- o Eat more fruits and vegetables
- o Offer healthy snack choices
- o Eat at the table with the TV off
- o Drink less sugary beverages
- o Avoid eating late at night (after 8pm)
- o Spend less time on "screens"
- o Eat less fast food/take out
- o Limit portion sizes at meals/snacks
- o Drink less soda/juice/punch/iced tea/sport drinks
- o Drink more water
- o Increase physical activity
- o Avoid eating emotionally (bored/stressed/happy/sad)

To be filled out by healthcare provider:
☐ All other systems have been reviewed and are negative.
☐ I have personally reviewed the above medical information questionnaire and agree with its contents. Physician signature: _____