mobilehealthteam.com
LIPIDS CLINIC

Mobile Health Team Kids Enrollment Questionnaire

Thank you for completing this form before your visit. When you come in for your initial appointment we will go over the history together. Leave blank any questions with which you are not familiar.

Child's Name_____ **Date**_____

Date of Birth_____ **Primary Care Provider:**_____

MEDICAL HISTORY Please check if your child has a history of the following:

	High Cholesterol		Fatty Liver or Jaundice		Asthma
	High Triglycerides		Diabetes (Type I or II)		Kidney Problems
	Heart Valve Problem		Pre-Diabetes (High Sugar)		Seizures and/or Epilepsy
	Septal Heart Defect		Thyroid Problems		Obesity
	High Blood Pressure		Gall Bladder Problems		Blood clotting Problems
	Rheumatic Heart Disease		Bowel (Intestine) Problems		Depression
	Heart Rhythm Problems		Stomach Problems		Anxiety or Panic Attacks
	Cancer or Tumors		Gastric Reflux (GERD)		Other:

Other:_____

Girls: Have you started menstruation? ____Yes ____No If yes, at what age? _____

SURGICAL HISTORY Please list any surgeries your child has had and the dates: _____

_____

_____

Please check if your child has any of the following **RECENT OR NEW CONCERNS**: None_____

	Recent Weight Changes		Heartburn or Indigestion		Rashes
	Hospitalizations		Weakness		Headaches
	Palpitations		Easy Bruising or Bleeding		Nausea, Vomiting or Diarrhea
	Chest Pain		Trouble Exercising		Infections
	Wheezing		Problems with Urination		*(Girls)* Irregular Periods
	Shortness of Breath		High or Low Blood Sugar		Joint Pains or Muscle Pains
	Abdominal Pain		Depression or Anxiety		Social/Emotional Problems
	Constipation		Social/EmotionalProblems		Seizures and/or Epilepsy

Other Concerns? _____

_____

BIRTH HISTORY: Was there a history of gestational (pregnancy) diabetes? ____Yes ____No

Were there any difficulties with the pregnancy or delivery? _____

Breast or bottle fed as a baby? ___*Breast* ____*Bottle* _____*Both*

Any developmental problems in early childhood (Speech, learning, etc)?_____

mobilehealthteam.com
LIPIDS CLINIC

CURRENT MEDICATIONS:

Prescriptions:_____

Over-the-counter medications or Herbal/Supplements: _____

ALLERGIES:

Has your child had medication allergies or severe side effects? ____Yes ____No

If yes, please list them with types of reactions: _____

Food, Environmental, Herbal/Supplements Allergies:_____

FAMILY HISTORY List history of family members with these problems & ages at onset:

High Blood Pressure_____ Coronary Artery Disease_____

High Cholesterol_____ Bypass Surgery_____

Diabetes_____ Heart Attacks_____

Strokes_____ Other_____

Heritage: (We ask this because certain genetic cholesterol and/or heart problems may occur in certain ethnic/racial groups.) Check all that apply: ___Dutch ___South African ___Asian __Hispanic __French Canadian __Jewish __African American ___Other (please list)_____

SIBLINGS: #Brothers _____ # Sisters _____ Names and ages of Siblings:

_____

SOCIAL HISTORY:

Who lives in your child's household? _____

Is there a second household your child spends significant time in? _____

Grade in School: _____ Name of School _____

Are there any smokers in the household? ____Yes ____No

HEALTHY LIVING

How worried are you about your child's health? ___ Not at all ___Somewhat ___Very Much

What types of exercise and physical activity does your child do? (Examples: Walking, running, sports teams, dancing, playing outside, gym class, recess, etc)? _____

_____

What does your child typically do afterschool? _____

What does you child typically do on weekends? _____

Please list one typical day of eating for your child: (include amounts, types – reg, low-fat, fat-free, etc) ?

Breakfast_____

Lunch_____

Dinner_____

Have you ever seen a Dietitian or Nutritionist for your family or child? ____Yes ____No

Does your family read food labels? ____Yes ____No Who does the food shopping? _____

mobilehealthteam.com
LIPIDS CLINIC

How many times **a day** does your child:

Eat Fruits ____1 _____ 2 _____3 _____4 _____5 or more

Eat Vegetables ____1 _____ 2 _____3 _____4 _____5 or more

Eat Whole Grains (whole grain breads or tortillas, brown rice, oatmeal, pasta) ___1 ___ 2 ____ 3 or more

Drink Water (Glass or Bottles **per DAY**) ____1 _____ 2 _____3 _____4 _____5 or more

Eat Desserts/Sugary Foods ____< 1 _____ 1 _____ 2 _____3 _____4 _____5 or more

Drink Glasses Milk (Type: __2% __1% __skim) ____< 1 _____ 1 _____ 2 _____3 _____4 ____5+

Drink Sugary Beverages (soda, pop, juice, Gatorade, Capri Sun, etc.) ____< 1 _____ 1 _____ 2 _____3+

Drink caffeine ____< 1 _____ 1 _____ 2 _____3 _____4 _____5 or more

Spend hours on Screens (weekdays) _____ 1-2 _____ 3-4 _____5 or more

Spend hours on Screens (weekend days) _____ 1-2 _____ 3-4 _____5 or more

How many times **a week** does your child:

Eat Lean Protein (fish, chicken, turkey, tofu, beans, eggs, etc) ___1 ___ 2 ____ 3 ___4 ____5 or more

Get 60 minutes of active play or exercise ____1 day _____ 2days _____3 _____4 _____5 or more

Eat fast food or eat out at a restaurant __1 time ___ 2 times ____ 3 _____4 _____5 or more

Skip Meals __1 time ___ 2 times ____ 3 _____4 _____5 or more

Which meal is missed most commonly: _____Breakfast _____ Lunch _____Dinner

MAKING CHANGES

Do you think your child needs to make changes in their nutrition and/or activity: ____Yes ____No

Is now a good time to make those changes? ____Yes ____No

On a scale of 1 to 5 (1 = confident, 5 = not at all confident), rate your confidence for making changes: __

Please check all the options you think could use improvement:

	More Fruits		Healthier Snacks		More Grains/Fiber
	More Vegetables		Smaller Portion Sizes		More Exercise
	Not Skipping Meals		Fewer Fats		Less Sitting
	Fewer Sugary Drinks		Less Sugar and/or Carbs		Other:

What would you like to be sure we cover during your visit with us? (Examples might include Education on a topic, Medication, Nutrition or Exercise help, Reassurance, etc. or specific questions.)

_____

_____

Thank you for taking the time to fill out this form. We look forward to meeting you!