ST JOHN PROVIDENCE.

CHILDREN'S HOSPITAL

Pediatric Weight Management Program
Initial Evaluation Form

DATE OF EVALUATION:

DEMOGRAPHIC INFORMATION

NAME _____

GENDER _____

DATE OF BIRTH _____

RACE _____

CURRENT PATIENT PHONE NUMBER _____

REFERRING PHYSICIAN _____

PHYSICIAN PHONE AND FAX NUMBER _____

MEDICAL HISTORY

OBESITY	YES	NO
HYPERLIPIDEMIA	YES	NO
HYPERTENSION	YES	NO
TYPE I DIABETES	YES	NO
TYPE 2 DIABETES	YES	NO
NASH	YES	NO
GERD	YES	NO
ASTHMA	YES	NO
THYROID DISORDER	YES	NO
	IF YES: _____	
CARDIOMYOPATHY	YES	NO
DEPRESSION / ANXIETY	YES	NO

SOCIAL HISTORY

TOBACCO USE	CURRENT	NEVER	PRIOR
ALCOHOL USE	CURRENT	NEVER	PRIOR
DRUG ABUSE	CURRENT	NEVER	PRIOR

CURRENT MEDICATIONS

_____

_____

_____

PHYSICAL EXAM

HEIGHT	_____
WEIGHT	_____
BMI	_____
WAIST CIRCUMFERENCE	_____
HR	_____
BP	_____

INITIAL LABORATORY VALUES (Requires 12 Hour Fast)

DATE OF LAB REPORT	_____
TOTAL CHOLESTEROL	_____
TRIGLYCERIDE	_____
LDL-C	_____
HDL-C	_____
GLUCOSE	_____
HbA1C	_____
TSH	_____
FREE T4	_____
VITAMIN D	_____
ALT	_____
AST	_____

Please fax this form to 313-343-4497.
Please call 313-343-7047 with any questions.