FOLLOW-UP EVALUATION: OBESITY CO-MORBIDITIES

Patient Name: _____ Phone#: _____ Date of Service:_____/_____/_____

Patient DOB:___/____/_____Age: ____ Accompanied by: ☐ Mom ☐ Dad ☐ Other: _____

Wt: _____kg Ht:_____ in BP: _____(___%ile) BMI:_____(____%ile) BMI Z Score: _____

Wt Change Since Last Visit: _____ kg

Allergies: ☐NKDA **Meds**: Rx_____ Non-Rx_____

INTERVAL HISTORY

HEALTHY LIFESTYLE RE-ASSESSMENT

MEALS:

Which meals do you eat daily? Breakfast / Lunch / Dinner
How many cups of sugary drinks per day?
Where do you usually eat meals? Table/ In front of TV
How often do you eat fast food? ____ time(s) per _____
How often do you eat snacks? _____
Notes: _____

EXERCISE:

How many hours of TV/ video games do you watch/play?_____
Do you have a TV in your bedroom? Yes / No
How many hours/day do you engage in physical activity? _____
Notes:_____
PROGRESS ON GOALS: _____

REVIEW OF SYSTEMS

Check if Problem

Constitutional
- ☐ Depression/Anxiety
- ☐ Fatigue

HEENT
- ☐ Snoring
- ☐ Sleep apnea

Respiratory
- ☐ Shortness of breath
- ☐ Wheezing/ Stridor

☐ **All other systems negative**

ROS Notes:

Cardiovascular
- ☐ Chest Pain

Gastrointestinal
- ☐ Abdominal pain

Neurologic
- ☐ Headache

Genitourinary
- ☐ Polyuria
- ☐ Polydipsia
- ☐ Nocturia
- ☐ Irregular menses

Musculoskeletal
- ☐ Joint pain

Psychosocial
- ☐ Being bullied

LAB RESULTS RECEIVED

- ☐ Fasting lipids Results:
- ☐ ASAT/ALAT _____
- ☐ Fasting blood glucose _____
- ☐ PCOS Labs: _____
- ☐ Sleep study: _____
- ☐ Other: _____ _____

PHYSICAL EXAM

Check if normal	Notes
☐ Eyes (no conjunctival injection, no papilledema)	
☐ ENT (tonsil size nl, no ext. ear pain, TM's clear, nasal mucosa nl, teeth/gums nl, oral-pharynx nl)	
☐ Neck (supple, no adenopathy/masses, thyroid nl)	
☐ Resp (clear, no retractions)	
☐ Heart (regular rhythm, no murmur)	
☐ Abd (nontender, no mas/organomegaly, bowel sounds nl)	
☐ Skin (no striae, no hirsutism)	
☐ Acanthosis nigricans None Mild Moderate Severe	
☐ Psych (normal affect & memory)	

ASSESSMENT

Weight Category
- ☐ Severely obese (BMI > 99% for Age)
- ☐ Obese (BMI ≥ 95% for Age)
- ☐ Overweight (BMI 85%-95% for Age)
- ☐ Normal weight (BMI 5-84% for Age)

RECOMMENDATIONS

1. Weight Management
- ☐ Counseling by PCP
- ☐ Nutritional Counseling
- ☐ Connecticut Children's
- ☐ 211/ Infoline
- ☐ Other: _____

2. Screening Labs
- ☐ Fasting lipids ☐ LFTs
- ☐ Fasting glucose ☐ PCOS labs
- ☐ Sleep Study ___ ☐ Other:_____

3. Referral to Ct. Children's:
- ☐ Endocrinology: **See referral guidelines**
- ☐ GI/ Hepatology
- ☐ Pulmonary ☐ ENT
- ☐ Nephrology ☐ Cardio
- ☐ Orthopaedics ☐ Other: _____
- ☐ Mental health
- ☐ Other: _____

4. Follow-Up with PCP_____/_____/_____

5. Other: _____

Patient/ Family Goals: 1._____
2. _____
3. _____

Signature: _____, **MD/APRN, PA-C Date :**_____

☐ **I saw and evaluated pt. with** _____, ☐ **I agree with A/P and Meds as written**
Attending _____, **MD Date:** _____ ☐ **I reviewed note**