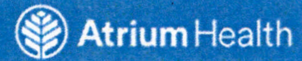
HEALTHY FUTURES CLINIC INTAKE



PATIENT MEDICAL HISTORY

Medical conditions: ____________________

Surgeries: ____________________

Medications: ____________________

Food/Drug Allergies: ____________________

Please check **YES-NO-NA** with comments as needed in the chart below.

	YES	NO	N/A	Comments
CARDIOVASCULAR				
Chest pain with exercise				
Heart murmur				
Heart palpitations or abnormal heart rhythm				
High blood pressure				
High cholesterol				
DEVELOPMENTAL				
ADHD				
Autism				
Learning problems				
Endocrine				
Regular periods				
Diabetes				
Thyroid problem				
EYE, EAR, NOSE & THROAT				
Allergies or chronic nasal congestion				
GASTROINTESTINAL				
Elevated liver enzymes				
Reflux				
Nausea or vomiting				
Right upper abdominal pain				
GENITOURINARY				
Frequent urination				
MUSCULOSKELETAL				
Joint pain				
Back pain				
Feet pain				
NEUROLOGICAL				
Headaches/ migraines more than once a week				
Blurry vision				
Dizziness				
Fainting				
Seizure disorder				

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PATIENT MEDICAL HISTORY (CONTINUED)

	Yes	No	N/A	Comments
PSYCHOLOGICAL				
Anxiety				
Depression				
RESPIRATORY				
Shortness of breath with exercise				
Cough with exercise				
Wheezing / Asthma				
SLEEP				
Snoring more than 3 nights per week				
Difficulty breathing during sleep (work hard to breath, or gasp for air, or periods when they stop breathing)				
School problems, or ADHD, or daytime sleepiness (fall asleep in class)				

At what age did you or your doctor become concerned about your child's weight? ____________________

Has your child already tried to lose weight? Yes No

If yes, what changes has your family already made? ____________________

Has your child tried another weight loss program or product? Yes No

If yes, which one? ____________________

Any concerns you'd like us to know about? ____________________

Anything we didn't ask about your child that you'd like us to know? ____________________

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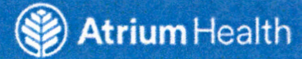

Family Medical History

Please check all that apply.

ILLNESS	MOTHER	FATHER	SIBLING	GRANDMA (MOM'S SIDE)	GRANDMA (DAD'S SIDE)	GRANDFATHER (MOM" SIDE)	GRANDFATHER (DAD" SIDE)
Bariatric Surgery							
Cancer							
Diabetes							
Heart attack or sudden cardiac death before the age of 50 years							
Heart Disease							
High Blood Pressure							
High Cholesterol							
Fatty Liver Disease							
Obstructive Sleep Apnea							
Struggle with weight loss							
Stroke							

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SOCIAL HISTORY

Home

Who lives at home with the child? ____________________

Who cares for the child during the day? ____________________

Parents of child are (circle one) Married Separated Divorced

Where does mom work? ____________________

Where does dad work? ____________________

Child lives in a (circle one) House Apartment Hotel

Child has a safe place to play outside (circle one) Yes No

We have reliable transportation (circle one) Yes No

Anyone smoke at home? (circle one) Yes No

School

What school does your child attend? ____________________ Grade __________

Does your child participate in an afterschool program? ____________________

My child is bullied (circle one) Yes No

Interests/Activities

What afterschool activities does your child participate in? ____________________

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LIFESTYLE HISTORY

1. How many meals a day does your child eat? ____________
2. How many snacks a day does your child eat? ____________
3. How many servings of fruit does your child eat per day? ____________
4. How many servings vegetables does your child eat per day? ____________
5. How many cups of water does your child drink per day? _______________
6. How many cups of fruit juice does your child drink per day? _______________
7. How many sugary beverages does your child drink per day? _______

   Sugary beverages include soda. sports drinks. sweet tea, coffee with sugar, lemonade, kool-aid, fruit punch.

8. How many days per week does your family eat fast food or food from a restaurant? ____________
9. In the past 12 months,

   we have worried about whether our food would run out before we got money to buy more. Yes or No?

10. In the past 12 months,

    the food we bought just didn't last and we just did not have money to get more. Yes or No?

11. How many minutes of physical activity does your child get per day? __________
12. Not including time doing homework, how many hours of screen time does your child get per day? ______

    Screen time includes TV, computer, tablet, iPad, smart phone, videogames.

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