Kids Health Alliance

Abnormal Weight Gain Questionnaire

Patient Name: _____ DOB_____ Date: _____

Do you exercise regularly? O Yes O No
If yes, what type of exercise? _____
Do you walk regularly? O Yes O No
How long do you walk? _____min/day
Are you involved in sports? O Yes O No
If yes, what type of sport? _____
Do you have a TV in your room? O Yes O No
How many hours a day do you watch TV? _____hrs
Do you play computer/video games? O Yes O No
If yes, how long do you play computer/video games? _____hrs
How much time do you spend on internet, computer, or tablet? _____hrs
What do you like to drink? O Water O Milk O Juice O Soda
O Power or Energy drinks O Coffee/Tea (Iced or Hot)
Please give amount _____glasses/cans or ounces/day
Do you eat breakfast? O Yes O No
Do you skip meals? O Yes O No
Do you eat fruits and vegetables every day? O Yes O No
If yes, how many much? _____servings/day
Do you eat out/fast food? O Yes O No
If yes, how often? _____times/week
Do you (family members) watch TV during meals? O Yes O No
Do you have hyper pigmentation around the neck? O Yes O No
Do you snore, have daytime sleepiness, or sleep apnea? O Yes O No
Do you have a neck mass or goiter? O Yes O No
Do you have heart burn, constipation or pain under right ribcage?
O Yes O No
Do you have joint pains or limping? O Yes O No
Do you have headaches, blurry vision or vision loss? O Yes O No
Do you have depression, poor self image, feelings of isolation from peers?
O Yes O No
(Girls Only) Delayed or heavy prolonged menses, excessive facial or body hair?
O Yes O No
Is there family history of *obesity, high cholesterol, hypertension, heart attack before 50yrs, thyroid issues, polycystic ovary disease*? If yes, please circle which one above.
O Yes O No