Chart Review Tool
Well child or overweight/obese visit: aged 2-19 years old

Site/Resident Information
1. Clinic site: 
2. Information about resident: Year: □1 □2 □3 □ Other(specify): 
3. Specialty: □Peds □FP □other 
4. Attending: 

Visit/Patient Information
5. Date of visit: 
6. Well child visit: □Yes □No 

7. If no to item 6, was overweight/obesity addressed at this visit? □ Yes □ No IF NO: DO NOT CONTINUE 

8. Child’s birth month and year: 
9. Gender: □M □F 

Anthropometrics
10. Measurements taken? □Yes □No 
   □Height: ____ □Weight: ____ 
   □inches □cm □lbs □kg 
11. BMI calculated? □Yes □No 
   □Value: 
12. BMI plotted? □Yes □No 
   □BMI %tile (for age/gender): 
13. BMI classified in the assessment? □Yes □No 
   □Underweight □Healthy Weight □Overweight □Obese □>99% 
   □Other(specify): 

Blood Pressure
14. BP measured? □Yes □No 
   □Value: 
15. BP classified in the assessment? □Yes □No 
   □Normal □High □Other(specify): 

Assessments & Counseling

<table>
<thead>
<tr>
<th>Nutrition Topic</th>
<th>Evidence that Provider Assessed?</th>
<th>Evidence that Provider Gave Counseling?</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. # sugar-sweetened beverages</td>
<td>□Yes □No</td>
<td>□Yes □No</td>
</tr>
<tr>
<td>17. Portion size</td>
<td>□Yes □No</td>
<td>□Yes □No</td>
</tr>
<tr>
<td>18. Frequency of meals prepared at home</td>
<td>□Yes □No</td>
<td>□Yes □No</td>
</tr>
<tr>
<td>19. Frequency of fast food meals</td>
<td>□Yes □No</td>
<td>□Yes □No</td>
</tr>
<tr>
<td>20. Eating breakfast daily</td>
<td>□Yes □No</td>
<td>□Yes □No</td>
</tr>
<tr>
<td>21. Fruit/Vegetable intake</td>
<td>□Yes □No</td>
<td>□Yes □No</td>
</tr>
<tr>
<td>22. Frequency of high caloric density foods (e.g. chips, cookies, etc)</td>
<td>□Yes □No</td>
<td>□Yes □No</td>
</tr>
<tr>
<td>23. Other(specify):</td>
<td>□Yes □No</td>
<td>□Yes □No</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Physical Activity Topic</th>
<th>Evidence that Provider Assessed?</th>
<th>Evidence that Provider Gave Counseling?</th>
</tr>
</thead>
</table>
24. Time spent in moderate-vigorous activity

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
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25. TV viewing/screen time

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
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</table>

26. Other(specify):

<table>
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<tr>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Additional information to be gathered from charts of overweight/obese patients only**

27. Evidence that family history has been assessed (anywhere in chart):

- Yes
- No

*If yes, which of the following assessed:*

- Obesity
- Type 2 DM
- CVD (HTN, high cholesterol)
- Early death from heart disease or stroke
- Other(specify): _____

28. Evidence that signs and symptoms of obesity assessed in the last 12 months (anywhere in the chart):

- Yes
- No

*If yes, which of the following assessed:*

- School problems
- Anxiety, social isolation, depression
- Headaches
- Sleep problems (OSA sx)
- Joint Pains
- Other(specify): _____

29. Laboratory exams ordered (include most recent date ordered):

- Fasting Lipid Panel
- AST/ALT
- Fasting Glucose
- BUN/Cr

<table>
<thead>
<tr>
<th>Test</th>
<th>Date</th>
</tr>
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</table>

30. Past BMI (or height/weight if BMI not available)

<table>
<thead>
<tr>
<th>Date</th>
<th>BMI</th>
<th>Height/Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 months ago</td>
<td>Ht:</td>
<td>Wt:</td>
</tr>
<tr>
<td>4 months ago</td>
<td>Ht:</td>
<td>Wt:</td>
</tr>
<tr>
<td>6 months ago</td>
<td>Ht:</td>
<td>Wt:</td>
</tr>
</tbody>
</table>

31. Additional Counseling Provided: CHECK ALL THAT APPLY

- Assessment of available community resources for physical activity
- Assessment of confidence and/or readiness to change behavior
- Behavior change self-management goal set (with either parent or child)
- Success and/or challenge with self-management goal from last visit noted
- Other(specify): _____

32. Referrals Made: CHECK ALL THAT APPLY

- For co-morbidity to (e.g. specialist); specify: _____
- To multidisciplinary obesity clinic
- To community based program; specify: _____
- Referral suggested, but family refused; specify: _____
- Other(specify): _____

33. Follow-up visit scheduled for weight-related issues:
☐ Yes; in _____ weeks/months (circle one) ☐ No

Chart Review Tool:
Well child aged ≤6 months old

Site/Resident Information
1. Clinic site: ______________________
2. Year of resident seeing patient: ☐ 1 ☐ 2 ☐ 3 ☐ other (specify______)
3. Specialty: ☐ Peds ☐ FP ☐ Other(specify):______
4. Attending: ______________________

Visit/Patient Information

5. Date of visit: _____
6. Type of visit:
   a. Well child visit: ☐ Yes ☐ No
   b. Jaundice visit ☐ Yes ☐ No
   c. Weight check visit ☐ Yes ☐ No

If NO to ALL above: STOP; If YES to any one of them, continue

7. Month/year of birth: _____
8. Gender: ☐ M ☐ F

Measurements

<table>
<thead>
<tr>
<th>9. Measurements taken?</th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Length: _____</td>
<td>Weight: _____</td>
</tr>
<tr>
<td></td>
<td>inches cm</td>
<td>lbs kg</td>
</tr>
</tbody>
</table>

Breastfeeding Assessment

10. Breastfeeding status
    ☐ Breastfed exclusively (no formula or solids)
    ☐ Breast fed and supplementation (with formula or other)
    ☐ No breastfeeding
    ☐ Unable to Determine

11. Counseled to breastfeed exclusively until 6 months of age?
    ☐ Yes ☐ No ☐ Unable to Determine

12. Counseled to continue breastfeeding until 12 months of age?
    ☐ Yes ☐ No ☐ Unable to Determine