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

Blood Pressure

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

Assessments & Counseling

Nutrition Topic	Evidence that Provider Assessed?	Evidence that Provider Gave Counseling?
16. # sugar-sweetened beverages	☐Yes ☐No	☐Yes ☐No
17. Portion size	☐Yes ☐No	☐Yes ☐No
18. Frequency of meals prepared at home	☐Yes ☐No	☐Yes ☐No
19. Frequency of fast food meals	☐Yes ☐No	☐Yes ☐No
20. Eating breakfast daily	☐Yes ☐No	☐Yes ☐No
21. Fruit/Vegetable intake	☐Yes ☐No	☐Yes ☐No
22. Frequency of high caloric density foods (e.g. chips, cookies, etc)	☐Yes ☐No	☐Yes ☐No
23. Other(specify):	☐Yes ☐No	☐Yes ☐No
Physical Activity Topic	**Evidence that Provider Assessed?**	**Evidence that Provider Gave Counseling?**

24. Time spent in moderate-vigorous activity	☐Yes	☐No	☐Yes	☐No
25. TV viewing/screen time	☐Yes	☐No	☐Yes	☐No
26. Other(specify):	☐Yes	☐No	☐Yes	☐No

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 Date:_____

☐AST/ALT Date:_____

☐Fasting Glucose Date:_____

☐BUN/Cr Date:_____

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

	DATE	BMI	Height/Weight
2 months ago			Ht: Wt:
4 months ago			Ht: Wt:
6 months ago			Ht: Wt:

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

9. Measurements taken?	☐Yes Length: _____ Weight: _____ ☐inches ☐cm ☐lbs ☐kg	☐No

Breastfeeding Assessment

10. Breastfeeding status	☐Breastfed exclusively (no formula or solids)	☐Breast fed and supplementation (with formula or other)	☐No breastfeeding **(STOP HERE)**	☐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	