PEDIATRIC CHOLESTEROL INTAKE

Please fill out completely using dark pen. Mark checkboxes clearly.

PATIENT DEMOGRAPHICS

Patient Name: _____ Date of Birth: _____

Today's Date: _____ Person Filling Out Form: _____

CHOLESTEROL HISTORY

1. How was high cholesterol discovered?
[ ] Routine screening [ ] Family history screening [ ] Found incidentally [ ] Other: _____

2. When was it first identified? [ ] New/Just found Months ago: _____ Years ago: _____

3. Has Lp(a) ever been checked? [ ] No [ ] Yes [ ] Don't know

4. Has patient ever taken cholesterol medication? [ ] No [ ] Yes → Name(s): _____

5. Any muscle pain, weakness, or cramps with cholesterol medication?
[ ] No [ ] Yes → Describe: _____ [ ] N/A (never taken)

MEDICAL HISTORY

Certain conditions can cause or worsen high cholesterol. Check all that apply:

[ ] Hypothyroidism (low thyroid)	[ ] Type 1 Diabetes	[ ] Type 2 Diabetes
[ ] Kidney disease / Nephrotic syndrome	[ ] Liver disease	[ ] Obesity
[ ] Pancreatitis	[ ] Polycystic ovary syndrome	[ ] Anorexia nervosa
[ ] Kawasaki disease	[ ] Heart transplant	[ ] Cancer survivor
[ ] Hypertension	[ ] Chronic inflammatory disease	[ ] HIV infection

[ ] Known genetic syndrome: _____ [ ] Other: _____

Menstrual history (if applicable): [ ] Regular [ ] Irregular [ ] Not yet started [ ] N/A

FAMILY HISTORY (Parents, Siblings, Grandparents, Aunts/Uncles)

Family history is critical in pediatric cholesterol disorders.

Condition	Who has this? (e.g., Mom, paternal grandpa)	Age diagnosed
High cholesterol		
Heart attack (men <55, women <65)		
Stroke (men <55, women <65)		
Stents / Bypass / Heart disease		
Sudden unexplained death		
Familial Hypercholesterolemia (FH)		
Diabetes (Type 1 or 2)		

CURRENT MEDICATIONS & SUBSTANCES

List ALL current medications, vitamins, and supplements:

Medication Name	Dose/Strength	How often?

Drug/Food Allergies: _____

Medications that can affect cholesterol (check if currently taking):

[ ] Steroids (prednisone, etc.) [ ] Birth control pills [ ] Accutane (isotretinoin)

[ ] Beta-blockers [ ] Thiazide diuretics [ ] Antiretrovirals (HIV meds)

[ ] Antipsychotics [ ] Immunosuppressants [ ] Anticonvulsants

Supplements & Substances:

[ ] Fish oil / Omega-3 supplements [ ] Other vitamins/supplements [ ] Protein powders

[ ] Tobacco / Vaping / Nicotine [ ] Alcohol use [ ] Caffeine / Energy drinks

SYMPTOMS (Check if present)

Most children with high cholesterol have no symptoms. These help identify secondary causes.

Symptom	No	Yes	If yes, details
Abdominal pain	[ ]	[ ]	
Muscle aches or weakness	[ ]	[ ]	
Fatigue / Low energy	[ ]	[ ]	
Skin changes / Yellow bumps on skin	[ ]	[ ]	
Cold intolerance / Constipation (thyroid)	[ ]	[ ]	
Excessive thirst / Frequent urination (diabetes)	[ ]	[ ]	

DIET & NUTRITION

Diet is the cornerstone of managing high cholesterol in children.

1. What type of food does your family usually eat? (Check all that apply)

[ ] American [ ] Mexican/Latin [ ] Southern [ ] Asian [ ] Indian

[ ] Mediterranean [ ] Caribbean [ ] African [ ] Other: _____

2. Food allergies or intolerances: _____

3. Dietary restrictions: [ ] Vegetarian [ ] Vegan [ ] Halal [ ] Kosher [ ] Other: _____

4. How often does your child eat the following?

Food	Daily	Few x/wk	Weekly	Rarely
Fried foods / Fast food	[ ]	[ ]	[ ]	[ ]
Red meat / Processed meats (hot dogs, bacon)	[ ]	[ ]	[ ]	[ ]
Full-fat dairy (whole milk, cheese, ice cream)	[ ]	[ ]	[ ]	[ ]
Chips, packaged snacks, baked goods	[ ]	[ ]	[ ]	[ ]
Sugary drinks (soda, juice, sweet tea)	[ ]	[ ]	[ ]	[ ]
Fish (salmon, tuna, etc.)	[ ]	[ ]	[ ]	[ ]
Fruits and vegetables	[ ]	[ ]	[ ]	[ ]
Whole grains (oatmeal, brown rice, whole wheat)	[ ]	[ ]	[ ]	[ ]
Nuts / Seeds	[ ]	[ ]	[ ]	[ ]

5. Meals — Breakfast: [ ] Home [ ] School [ ] Skips Lunch: [ ] Home [ ] School

6. Who does most of the cooking at home? _____

7. Ever seen a dietitian? [ ] No [ ] Yes Interested in nutrition referral? [ ] Yes [ ] No

EXERCISE & ACTIVITY

1. Overall physical activity level: [ ] Daily [ ] Few times/week [ ] Weekly [ ] Rarely

2. PE at school? [ ] No [ ] Yes → How often? [ ] Daily [ ] Few times/week

3. Current sports or activities: _____

4. Activities child WANTS to try: _____

5. Physical limitations to exercise? [ ] No [ ] Yes: _____

6. Screen time (TV, phone, gaming): [ ] < 2 hrs/day [ ] 2-4 hrs/day [ ] > 4 hrs/day

HOME & LOGISTICS

1. What city/town/parish do you live in? _____
2. Who else lives in the home? _____
3. After-school situation:

[ ] Home (with adult) [ ] Home alone [ ] After-school program [ ] Relative's house

4. Who is in charge of meals at home? _____
5. Is that person here today? [ ] Yes [ ] No

6. Any barriers to healthy eating? (Check all that apply)

[ ] Cost of healthy foods	[ ] Limited grocery store access	[ ] Picky eater
[ ] Time to prepare meals	[ ] Other family members' preferences	[ ] Cultural food traditions
[ ] Child eats out often	[ ] Not sure what's healthy	[ ] Other: _____

READINESS FOR CHANGE

On a scale of 1-10, how ready is your family to make dietary changes?

1	2	3	4	5	6	7	8	9	10

Not Ready Ready Now

What healthy changes has your family already made?

_____

What's the BIGGEST barrier to eating healthier?

_____

YOUR QUESTIONS & CONCERNS

What concerns you MOST about your child's cholesterol?

_____

_____

What questions do you have for the doctor today?

_____

_____

ANYTHING ELSE we should know?

_____

_____

OFFICE USE ONLY

Height: _____	Weight: _____	BMI: _____	BMI %ile: _____
BP: _____ / _____	HR: _____		

Thank you for completing this form. Please return it to the front desk.