Independence Park Medical Services

Dr. Cydney Fenton

Specializing in Pediatric Endocrinology

9500 Independence Dr. #900

Anchorage, AK 99507

Clinic Phone: (907) 522-1341 • Fax: (907) 522-1343

https://www.ipmsak.com/

NEW PATIENT PAPERWORK

ATTENTION PARENTS:

Please complete the questionnaire to the best of your ability. It will be extremely helpful in the initial evaluation of your child. **BRING IT WITH YOU** to the scheduled appointment in our clinic. If you do not know the answers, please write DON'T KNOW in the appropriate blanks. Thank you for completing this form.

Today's date _____

Child's full name: _____ **DOB:** _____ **mm/dd/year**
Child's preferred first name or nickname: _____
Child's full home address: _____

Child's Race (please circle): American Indian or AK Native / Asian, Black or African American / Native Hawaiian or Other Pacific Islander / other / White or Caucasian / Unknown or Refused to answer?

Childs Ethnicity (please circle): Hispanic or Latino / Not Hispanic or Latino / unknown / refused to answer?

Legal Guardian name? _____ **Relation** (please circle) Mother / Father / Other
Best Contact phone number: (___) _____

Legal Guardian name? _____ **Relation** (please circle) Mother / Father / Other
Best Contact phone number: (___) _____ (different from above)

Name of primary care physician: _____
Name of School: _____ **Grade:** _____
Name of person filing out form today: _____**Relation**: _____

Briefly describe in your own words, the reason for coming to see the Endocrinologist

Briefly describe in your own words, what you would like to get out of the appointment today

Age of mother at delivery: _____ Weeks pregnant at delivery? _____

Was your delivery: Vaginal _____ C-Section _____

Any miscarriages or elective abortions? YES / NO

Any alcohol, tobacco, or street drugs used during pregnancy? YES / NO (if yes please list below)

_____

List ANY medications taken during pregnancy (include over the counter, herbals and vitamins):

_____

Medical problems occurring with pregnancy? YES / NO (if yes please describe)

_____

Medical problems occurring with delivery? YES / NO (if yes please describe)

_____

Birth Weight: _____ Birth Length: _____
Did you breast feed? YES / NO **If yes, how long? _____**

Any other information about the pregnancy, delivery, and newborn period you feel we should be aware of?

YOUR CHILDS EARLY DEVELOPMENT

Were you concerned about when your child began to smile, rollover, sit alone, crawl, cruise or walk?
YES / NO (if yes please explain)

_____
_____

Do you have concerns about your child's vision, hearing or speech? YES / NO (if yes please explain)

_____
_____

Has your child lost any developmental skills they once had? YES / NO (if yes please explain)

_____
_____

How does your child perform in school?

_____
_____

Has your child ever had any serious medical problems? YES / NO (If yes please explain)

_____
_____

Has your child ever been hospitalized for illness or evaluation of a medical problem? YES / NO
(If yes please give reason and age at time of admission) _____
_____

Has your child ever had any surgery? YES / NO (If yes please give reason and age at time of surgery)
_____
_____

Has your child ever broken any bones? YES / NO (if yes please explain)
_____

Has your child had all the immunizations for their age? YES / NO

What medications is your child currently taking? Please include prescriptions, herbals, essential oils, and any over the counter medications and/ or vitamins. Please provide current dose for each.
_____
_____
_____

What medications has your child taken in the past?
_____
_____

Does your child have any medication, environmental or food allergies? YES / NO (if yes please list below)
_____

Please provide the approximate age when your child began showing the following signs of puberty:

	Age		Age		Age
Pimples		**Voice Change**		**Underarm Hair**	
Pubic Hair		**Body Odor**		**Shaving Face**	
Breasts		**Vaginal Bleeding**			

Are there any products in the home that may contain hormones (birth control pills, testosterone, estrogen, etc.)
YES / NO (if yes please list) _____
_____

FAMILY HISTORY

CHILDS FAMILY MEMBERS:

AGE(S)	HEIGHT	WEIGHT	MEDICAL PROBLEMS	PUBERTY / AGE OF 1ST PERIOD
MOTHER:				
FATHER:				
SISTERS:				
BROTHERS:				

Do any of these medical conditions run in the child's immediate family?
Please use the following to list relations

M=Mothers Side
M=Mother
MGM=child's grandmother
MGF= child's grandfather
MA= child's Aunt
MU= child's Uncle
B= child's Brother
S= child's Sister

P= Fathers Side
P= Father
PGM= child's grandmother
PGF= child's grandfather
PA= child's Aunt
PU= child's Uncle

	NO		YES	If yes, list who is affected
Diabetes				
Thyroid Disorders				
High blood Pressure				
Celiac				
Autoimmune Disorder				
High Cholesterol				
Obesity				

SOCIAL HISTORY

Who lives in the household with your child? _____

_____

Who is your child's primary support person? _____

_____

What activities or sports does your child participate in?

_____

Number of regular soda-pops (not diet) does your child drink each day? _____
Number of times a week meals are eaten outside the home? _____
Number of fried foods eaten weekly? _____
Average hours of screen time watched each day? _____
Does your child drink milk? How many glasses a day of 1%___2% ___Whole Milk ____
Any thicker, darker skin in the crease of neck? YES / NO