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/

PATIENT UPDATE

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: _____

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**: _____

What condition does Dr. Fenton follow your child for? _____
_____

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 broken any bones? YES / NO (if yes please explain)

_____

Has your child received 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.

_____
_____
_____

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

_____

SOCIAL HISTORY

Who lives in the household your child? _____
_____

Who is your child's primary support person? _____
_____

What activities or sports does your child participate in?

_____

How many regular soda-pops (not diet) does your child drink each day? _____

How many meals a week are eaten outside the home? _____

What is the number of fried foods eaten weekly? _____

What are the average hours of screen time watched each day? _____

Does your child drink milk? How many glasses a day of 1%___2% ___Whole Milk ____

Have you noticed any thicker, darker skin in the crease of neck? YES / NO

Any updates to family history? _____
_____