

Ellicott City Pediatric Associates, PA

Patient Name:

BORN:

AGE:

Allergies:

Date of last check-up:

What activity will you be participating in: _____

This form is to be used during the interval between well visits to document continued good health for activities. It is not a substitute for a regular physical examination. Please correct any information printed out above by the computer. Any positive responses to the question should prompt medical evaluation.

ACTIVITY PARTICIPATION, MEDICAL HISTORY UPDATE FORM

1. Have you ever been diagnosed with COVID-19? Yes ☐ No ☐

(cough, cold, bronchitis, or other infection)

Were you hospitalized? Yes ☐ No ☐

How many days did the symptoms last? _____

2. Have you missed more than 3 consecutive days of participation in usual activities because of an injury this past year? Yes ☐ No ☐

If yes, please indicate below

a. Site of injury _____

b. Type of injury _____

3. Have you missed more than 5 consecutive days of participation in usual activities because of an illness, or have you had a medical illness diagnosed that has not resolved in this past year? Yes ☐ No ☐

If yes, please indicate below

a. Type of illness: _____

4. Have you had a seizure, concussion, or been unconscious for any reason in the past year? Yes ☐ No ☐

Explain: _____

5. Have you had any surgery or been hospitalized in this past year? Yes ☐ No ☐

If yes, please indicate below

a. Reason for hospitalization _____

b. Type of surgery _____

6. List all medications you are taking now, or have taken in the past year, and what condition you are taking it for.

7. Are you worried about any problem or condition at this time? Yes ☐ No ☐

If yes, please explain: _____

8. Immunizations up to date? Yes ☐ No ☐

9. Do you wear glasses? ☐ Yes ☐ No Contacts? ☐ Yes ☐ No

10. Do you have braces? ☐ Yes ☐ No Dental appliance? ☐ Yes ☐ No

11. Current Weight: _____ Height: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Portal ☐ Pick up ☐

Signature of parent/guardian/patient _____

Number to call when form is ready _____

Date _____

FOR OFFICE USE ONLY: NURSE/DOCTORS

Signature of reviewing clinician, who ...

Comment/Waiting for: _____

Date Called: _____ Spoke With: _____

FOR BILLING USE ONLY:

Fee Charge: \$ _____

Fee Paid: Y/N

FOR FRONT DESK USE ONLY:

Form ready for pick-up notified who: _____ on: _____

Form picked up on: _____ By Whom: _____

Staff Initials: _____

WHEN FORM IS PICKED UP... PARENT/GUARDIAN/PATIENT picking up form

Please Print Your Name Here

Signature of Parent/Guardian/Patient

Date