Ellicott City Pediatric Associates, PA

Patient Name: **BORN:** **AGE:**

Allergies: **Date of last check-up:**

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. Over the next 12 months, I wish to participate in the following sports, club, instruments, or other activities:

a. ______________________________

b. ______________________________

c. ______________________________

d. ______________________________

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.

a. ____________________ ____________________

b. ____________________ ____________________

c. ____________________ ____________________

d. ____________________ ____________________

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? Y / N, Contacts? Y / N

____

10. Do you have braces? Y / N, Dental appliance? Y / N

____

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

______________________________ **( ) Signed Form, ( ) Advised to come in for medical evaluation:**

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**