

ChildrensPeds.com

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**INTERIM HEALTH QUESTIONNAIRE**

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Since your child's last physical exam:

- |     |   |       |    |
|-----|---|-------|----|
| 1.  | Have you been told by a doctor they have asthma, diabetes, seizures or heart disease?                                   | YES   | NO |
| 2.  | Have they spent the night in a hospital, or been treated in an Emergency room or an urgent care facility?               | YES   | NO |
| 3.  | Have they had any surgery?  | YES   | NO |
| 4.  | Have they had an injury that required X-rays, MRI, CT scan, injections, a brace, a cast, crutches, or physical therapy? | YES   | NO |
| 5.  | Does their heart race or skip beats during exercise?  | YES   | NO |
| 6.  | Did they pass out or nearly do so during or after exercise?   | YES   | NO |
| 7.  | Were they diagnosed with a concussion?  | YES   | NO |
| 8.  | Did they have a blow to the head that caused confusion, prolonged headaches, or memory problems?                        | YES   | NO |
| 9.  | Have they had to see a chiropractor, orthopedic surgeon, neurologist, or physical therapist in the past year?           | YES   | NO |
| 10. | Did they have an injury that caused them to miss practice or a game?  | YES   | NO |
| 11. | Do you know of any reason your child cannot participate in sports?  | YES   | NO |
| 12. | Has your child been diagnosed with a confirmed or suspected case of coronavirus (COVID-19)?                             | YES   | NO |
|     | If yes, when was the date of the diagnosis?   | _____ |    |

If you answered "yes" to any question, please give details below:

\_\_\_\_\_

\_\_\_\_\_

**\*\*NOTE\*\*** Your child must have had a well child visit by us within the last twelve months for us to complete school or daycare forms.

**\*\*NOTE\*\*** If you are asking for a sports form or drivers permit form and it has been more than 4 months since your child's last well child or there has been a change in their health since that well child visit, in the best interest of your child's health and to be in line with current guidelines, we ask that you make an appointment for a sport's/drivers exam for completion of the form.

Parent / Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please provide a phone number for us to call when form is ready for pick-up. \_\_\_\_\_