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New Hampshire Musculoskeletal Institute
ADVANCING KNOWLEDGE. ADVANCING CARE.

Safe Sports network

FREE SPORTS PHYSICALS

Presented By:

New Hampshire ORTHOPAEDIC CENTER

Please understand that these physicals are designed specifically for sports participation and they are intended as a supplement to, rather than a substitute for, ongoing health care by a family physician or other specialist. These physicals are not designed to treat or evaluate chronic medical conditions. If your son or daughter is presently under a physician's care for any chronic medical condition, he or she must receive clearance for sports participation by that physician. Also, you must understand that there are some health conditions which cannot be detected by routine physical. If you have any concerns about your child's health, you should discuss them with your family physician or other specialist.

Physicals will be held at Salem Sports & Rehab, 13 Red Roof Lane, Salem, NH, on Tuesday, June 12, 2012. Physicals will be offered from 5-8 p.m. This is the only available date/time for 2012. **Athletes should bathe prior to arrival and dress in shorts and T-shirt.**

Arrival Times: **Pelham/Windham .....5:00 p.m.**
Salem..... After 6:00 p.m. only please.

Please provide the information requested on this page, and on the two inside pages of this form. It is recommended that you and your child fill out the form together in order to ensure the information given is as complete and as accurate as possible. Forms signed and received at our facility by May 31 qualify for pre-registration. Walk-ins are welcome, but not recommended. Please submit form online or drop off/mail to: Sports & Rehab, 13 Red Roof Ln., Suite 2, Salem, NH, 03079.

Signature of parent or guardian is **required** if athlete is under 18 years of age.

Last Name_____First Name_____MI_____

DOB_____Age_____ Sex ☐M ☐F Home Phone_____

Address_____Alabama_____
Street City State Zip

School (next fall)_____Grade (next fall) _____

Emergency Contact_____ Phone_____ _____
Work Home

Guardian Email_____

Last name: First name: School:

Medical/Injury History

Personal Physician: Test Data

Please answer the questions below and on the next page, explaining "yes" answers in the space provided on the next page.

1. Has a doctor ever denied or restricted your participation in sports for any reason? ☐ Yes ☐ No
2. Do you have an ongoing medical condition (like diabetes, asthma, blood clotting disease)? ☐ Yes ☐ No
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines, pills or inhalers? ☐ Yes ☐ No
4. Do you have allergies to medicines, pollens, foods or stinging insects? ☐ Yes ☐ No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise? ☐ Yes ☐ No
6. Have you ever had discomfort, pain or pressure in your chest during exercise? ☐ Yes ☐ No
7. Does your heart race or skip beats during exercise? ☐ Yes ☐ No
8. Has a doctor ever told you that you have (check all that apply):
   - High blood pressure ☐ Yes ☐ No
   - A heart murmur ☐ Yes ☐ No
   - High cholesterol ☐ Yes ☐ No
   - A heart infection ☐ Yes ☐ No
9. Has a doctor ever ordered a test for your heart (for example, ECG, echocardiogram)? ☐ Yes ☐ No
10. Does anyone in your family have a heart problem? ☐ Yes ☐ No
11. Has any family member or relative died of heart problems or of sudden death before age 50? ☐ Yes ☐ No
12. Has anyone in your family had unexplained fainting, seizures, or near drowning? ☐ Yes ☐ No
13. Does anyone in your family have Marfan syndrome? ☐ Yes ☐ No
14. Have you ever spent the night in a hospital? ☐ Yes ☐ No
15. Have you ever had surgery? ☐ Yes ☐ No
16. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis that caused you to miss a practice or game? If yes, check the affected area below: ☐ Yes ☐ No
17. Have you had any broken or fractured bones or dislocated joints? Have you ever had a stress fracture? If yes, Check below: ☐ Yes ☐ No
18. Have you ever had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches? If yes, Check below: ☐ Yes ☐ No

Head ☐	Neck ☐	Shoulder ☐	Upper arm ☐	Elbow ☐	Forearm ☐	Hand/ fingers ☐	Chest ☐
Upper back ☐	Lower back ☐	Hip ☐	Thigh ☐	Knee ☐	Calf/shin ☐	Ankle ☐	Foot/ toes ☐

19. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? ☐ Yes ☐ No
20. Do you regularly use a brace or assistive device? ☐ Yes ☐ No
21. Has a doctor ever told you that you have asthma or allergies? ☐ Yes ☐ No
22. Do you cough, wheeze, or have difficulty breathing during or after exercise? ☐ Yes ☐ No
23. Is there anyone in your family who has asthma? ☐ Yes ☐ No
24. Have you ever used an inhaler or taken asthma medicine? ☐ Yes ☐ No
25. Were you born without, or are you missing, a kidney, an eye, a testicle, or any other organ? ☐ Yes ☐ No

26. Have you had infectious mononucleosis (mono) within the last month? ☐ Yes ☐ No
27. Do you have any rashes, pressure sores, or other skin problems? ☐ Yes ☐ No
28. Have you had a herpes or MRSA (staph) skin infection? ☐ Yes ☐ No
29. Have you ever had a head injury or concussion? ☐ Yes ☐ No
30. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? ☐ Yes ☐ No
31. Have you ever had a seizure? ☐ Yes ☐ No
32. Do you have headaches with exercise? ☐ Yes ☐ No
33. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? Have you ever had a stinger, burner, or pinched nerve? ☐ Yes ☐ No
34. Have you ever been unable to move your arms or legs after being hit or falling? ☐ Yes ☐ No
35. When exercising in the heat, do you have severe muscle cramps or become ill? ☐ Yes ☐ No
36. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? ☐ Yes ☐ No
37. Have you had any problems with your eyes or vision? ☐ Yes ☐ No
38. Do you wear glasses or contact lenses? ☐ Yes ☐ No
39. Do you wear protective eyewear, such as goggles or a face shield? ☐ Yes ☐ No
40. Are you happy with your weight? ☐ Yes ☐ No
41. Are you trying to gain or lose weight? ☐ Yes ☐ No
42. Has anyone recommended you change your weight or eating habits? ☐ Yes ☐ No
43. Do you limit or carefully control what you eat? ☐ Yes ☐ No
44. Do you have any concerns you would like to discuss with a doctor? ☐ Yes ☐ No

FEMALES ONLY

45. Have you ever had a menstrual period? ☐ Yes ☐ No
46. How old were you when you had your first menstrual period? _____
47. How many periods have you had in the past 12 months? _____

Explain “yes” answers here:

I hereby state that, to the best of my knowledge, the answers to the above questions are complete and correct. I also certify that I have read and understand the statement on the first page of this form. Further, I am aware that the names (only) of athletes who are cleared for sports participation are released to appropriate school athletic departments. No other information is released.

Signature of athlete Signature of parent/guardian Date

(For electronic submission, your typed names and date will be accepted as your signatures.)

PHYSICAL FORMS MUST BE RECEIVED BY MAY 31. FORMS MAY BE DROPPED OFF OR MAILED TO ADDRESS ON FRONT PAGE.

For office use only -- do not complete this page.

Preparticipation Physical Evaluation

Name _____Date of Birth_____

Height _____Weight_____Pulse_____BP____/____ (____/____, ____/____)

Vision R 20/_____ L 20/_____ Corrected **Y N** **Pupils Equal Y N**

	Normal	Abnormal Findings	Initials
Musculoskeletal			
Neck/back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			
Medical			
Appearance			
Eyes/ears/nose/throat			
Lymph nodes			
Heart/pulses/murmurs			
Lungs			
Abdomen			
Genitourinary (males)			
Skin			

NOTES_____

_____

_____

_____

_____

_____

_____

CLEARED _____ NOT CLEARED _____ REASON_____

RECOMMENDATIONS_____

Signature of Physician_____Date_____