**SEACOAST ORTHOPEDICS & SPORTS MEDICINE - 7 MARSH BROOK DRIVE, SOMERSWORTH, NH**

**HISTORY** **PRE-PARTICIPATION PHYSICAL EVALUATION**

Name: _____ Sex: _____ Age: _____ DOB: _____

School: _____ Grade: _____ Sports: _____

Address: _____ Phone: _____

Date of Exam: _____ Personal Physician: _____

*In Case of Emergency Contact: Name:* _____ *Relationship:* _____

*Phone: (H)* _____ *(W)* _____ *(Mobile)* _____

| **Explain "Yes" answers on back of this form** | **Yes** | **No** |
|---|---|---|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | ☐ | ☐ |
| 2. Do you have an ongoing medical condition (like diabetes or asthma)? | ☐ | ☐ |
| 3. Are you currently taking any prescription or nonprescription (over the counter) medicines or pills? | ☐ | ☐ |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects? | ☐ | ☐ |
| 5. Have you ever passed out or nearly passed out DURING exercise? | ☐ | ☐ |
| 6. Have you ever passed out or nearly passed out AFTER exercise? | ☐ | ☐ |
| 7. Have you ever had discomfort, pain or pressure in your chest during exercise? | ☐ | ☐ |
| 8. Does your heart race or skip beats during exercise? | ☐ | ☐ |
| 9. Has a doctor ever told you that you have (check all that apply) ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection | | |
| 10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) | ☐ | ☐ |
| 11. Has anyone in your family died for no apparent reason? | ☐ | ☐ |
| 12. Does anyone in your family have a heart problem? | ☐ | ☐ |
| 13. Has any family member or relative died of heart problems or of sudden death before age 50? | ☐ | ☐ |
| 14. Does anyone in your family have Marfan Syndrome? | ☐ | ☐ |
| 15. Have you ever spent the night in a hospital? | ☐ | ☐ |
| 16. Have you ever had surgery? | ☐ | ☐ |
| 17. Have you ever had an injury like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game? If yes, circle affected area below. | ☐ | ☐ |
| 18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below. | ☐ | ☐ |
| 19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, cast or crutches? If yes, circle below | ☐ | ☐ |
| Head Neck Shoulder Upper Arm Elbow Forearm Hand/ Fingers Chest | | |
| Upper Back Lower Back Hip Thigh Knee Calf/ Shin Ankle Foot/ Toes | | |
| 20. Have you ever had a stress fracture? | ☐ | ☐ |
| 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | ☐ | ☐ |
| 22. Do you regularly use a brace or assistive device? | ☐ | ☐ |
| 23. Has a doctor ever told you that you have asthma or allergies? | ☐ | ☐ |
| **Circle questions you do not have answers to.** | **Yes** | **No** |

| | | |
|---|---|---|
| 24. Do you cough, wheeze, or have difficulty breathing during or after exercise? | ☐ | ☐ |
| 25. Is there anyone in your family who has asthma? | ☐ | ☐ |
| 26. Have you ever used an inhaler or taken asthma medicine? | ☐ | ☐ |
| 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | ☐ | ☐ |
| 28. Have you had infectious mononucleosis (mono) within the last month? | ☐ | ☐ |
| 29. Do you have any rashes, pressure sores, or other skin problems? | ☐ | ☐ |
| 30. Have you had a herpes skin infection? | ☐ | ☐ |
| 31. Have you ever had a head injury or concussion? | ☐ | ☐ |
| 32. Have you been hit in the head and been confused or lost your memory? | ☐ | ☐ |
| 33. Have you ever had a seizure? | ☐ | ☐ |
| 34. Do you have headaches with exercise? | ☐ | ☐ |
| 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | ☐ | ☐ |
| 36. Have you ever been unable to move your arms or legs after being hit or falling? | ☐ | ☐ |
| 37. When exercising in the heat, do you have severe muscle cramps or become ill? | ☐ | ☐ |
| 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | ☐ | ☐ |
| 39. Have you had any problems with your eyes or vision? | ☐ | ☐ |
| 40. Do you wear glasses or contact lenses? | ☐ | ☐ |
| 41. Do you wear protective eyewear, such as goggles or a face shield? | ☐ | ☐ |
| 42. Are you happy with your weight? | ☐ | ☐ |
| 43. Are you trying to gain or lose weight? | ☐ | ☐ |
| 44. Has anyone recommended you change your weight or eating habits? | ☐ | ☐ |
| 45. Do you limit or carefully control what you eat? | ☐ | ☐ |
| 46. Do you have any concerns that you would like to discuss with a doctor? | ☐ | ☐ |

**FEMALES ONLY**

| | | |
|---|---|---|
| 47. Have you ever had a menstrual period? | ☐ | ☐ |

48. How old were you when you had your 1st menstrual period? _____

49. How many periods have you had in the last 12 months? _____

***Explain ALL "Yes" answers on back of this form.**

****PLEASE NOTE: ATHLETES UNDER THE AGE OF 18. Parent signature required. Parent encouraged to accompany athlete at time of physical.**

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

Signature of athlete: _____ Signature of parent/guardian: _____ Date: _____