

Dear Parent,

The Physicians and Staff of Pentucket Medical are very happy to offer the students of North Andover High School complimentary physicals for the Winter sports season. It is our way of thanking the community for its support of Pentucket Medical over the past 14 years and also of introducing you to our beautiful new facility at RiverWalk. ([Click for more information and directions to Pentucket Medical](#))

Below are the dates and times for the examinations. If your child requires a physical exam, please email me at [jsarro@pmaonline.com](mailto:jsarro@pmaonline.com) with your choice of a convenient date and approximate time. This step will allow us to adequately staff the event for to insure quality and efficiency.

Also, attached is a Medical History Questionnaire, which will provide our clinicians with the essential information, needed to assure that your child is able to safely participate in his/her, chosen sport. Please print up a copy of the completed questionnaire and bring it with you to the visit. If you have any questions, please call me anytime at (978) 469-5586.

All the Best,

John Sarro  
Executive Director

**SCHEDULE FOR SPORTS PHYSICALS - NORTH ANDOVER  
HIGH SCHOOL**

<b>DATE</b>	<b>CLINICIAN</b>	<b>TIME</b>
1-Nov	Suzanne Damiani, MD	9am - 12 noon
	Janet Espinosa, MD	9am - 12 noon
	Joseph Miller, NP	9am - 12 noon
	Dan Powers, DO	PM only
3-Nov	Suzanne Damiani, MD	9am - 5pm
	Janet Espinosa, MD	9am - 5pm
	Joseph Miller, NP	5pm - 8pm
	Dan Powers, DO	5pm - 8pm
8-Nov	Suzanne Damiani, MD	9am - 12 noon
	Janet Espinosa, MD	9am - 12 noon
11-Nov	Suzanne Damiani, MD	9am - 5pm
	Janet Espinosa, MD	9am - 5pm
	Joseph Miller, NP	5pm - 8pm
	Dan Powers, DO	5pm - 8pm

## Student Medical History Form

Part A: HEALTH HISTORY QUESTIONNAIRE – Completed by the parent and student and reviewed by examining provider  
 Part B: PHYSICAL EVALUATION FORM – Completed by examining licensed provider with MD, DO, APN, or PA

### Part A: HEALTH HISTORY QUESTIONNAIRE

Today's Date: \_\_\_\_\_ Date of Last Sports Physical: \_\_\_\_\_

Student's Name: \_\_\_\_\_ Sex: M F (circle one) Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ School: \_\_\_\_\_ District: \_\_\_\_\_

Sport(s): \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Name of parent/guardian: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Phone (work): \_\_\_\_\_ Phone (home): \_\_\_\_\_ Phone (cell): \_\_\_\_\_

Additional emergency contact: \_\_\_\_\_ Relationship to contact: \_\_\_\_\_

Phone (work): \_\_\_\_\_ Phone (home): \_\_\_\_\_ Phone (cell): \_\_\_\_\_

**Directions:** Please answer the following questions about the student's medical history by CIRCLING the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions.

1. Have you ever had, or do you currently have:
  - a. Restriction from sports for a health related problem? Y / N / Don't know
  - b. An injury or illness since your last exam? Y / N / Don't know
  - c. A chronic or ongoing illness (such as diabetes or asthma)? Y / N / Don't know
    - (1.) An inhaler or other prescription medicine to control asthma? Y / N / Don't know
  - d. Any prescribed or over the counter medications that you take on a regular basis? Y / N / Don't know
  - e. Surgery, hospitalization or any emergency room visit(s)? Y / N / Don't know
  - f. Any allergies to medications? Y / N / Don't know
  - g. Any allergies to bee stings, pollen, latex or foods? Y / N / Don't know
    - (1.) If yes, check type or reaction:  
 \_\_\_\_\_ Rash \_\_\_\_\_ Hives Breathing or other anaphylactic reaction Y / N / Don't know
    - (2.) Take any medication/Epipen taken for allergy symptoms? (List below.) Y / N / Don't know
  - h. Any anemia's, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders? Y / N / Don't know
  - i. A blood relative who died before age 50? Y / N / Don't know

Explain all "yes" answers here (include relevant dates):

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List all medications here:

Medication Name	Dosage	Frequency

2. Have you ever had, or do you currently have, any of the following *head related* conditions:
- |   |                    |
|---|--------------------|
| a. Concussion or head injury (including “bell rung” or a “ding”)? | Y / N / Don’t Know |
| b. Memory loss?   | Y / N / Don’t Know |
| c. Knocked out?   | Y / N / Don’t Know |
| d. A seizure?   | Y / N / Don’t Know |
| e. Frequent or severe headaches (With or without exercise)?       | Y / N / Don’t Know |
| f. Fuzzy or blurry vision   | Y / N / Don’t Know |
| g. Sensitivity to light/noise                                     | Y / N / Don’t Know |

Explain all “yes” answers here (include relevant dates):

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3. Have you ever had, or do you currently have, any of the following *heart-related* conditions:
- |   |                    |
|---|--------------------|
| a. Restriction from sports for heart problems?  | Y / N / Don’t Know |
| b. Chest pain or discomfort?  | Y / N / Don’t Know |
| c. Heart murmur?  | Y / N / Don’t Know |
| d. High blood pressure?   | Y / N / Don’t Know |
| e. Elevated cholesterol?  | Y / N / Don’t Know |
| f. Heart infection?   | Y / N / Don’t Know |
| g. Dizziness or passing out during or after exercise without known cause?                       | Y / N / Don’t Know |
| h. Has a provider ever ordered a heart test (EKG, echocardiogram, stress test, Holter monitor)? | Y / N / Don’t Know |
| i. Racing or skipping heartbeats?   | Y / N / Don’t Know |
| j. Unexplained difficulty breathing or fatigue during exercise?                                 | Y / N / Don’t Know |
| k. Any family member (blood relative):  |                    |
| (1.) Under age 50 with a heart condition?   | Y / N / Don’t Know |
| (2.) With Marfan Syndrome?  | Y / N / Don’t Know |
| (3.) Died of a heart problem before age 50? If yes, at what age? _____                          | Y / N / Don’t Know |
| (4.) Died with no known reason?   | Y / N / Don’t Know |
| (5.) Died while exercising? If yes, was it during or after? (Circle one.)                       | Y / N / Don’t Know |

Explain all “yes” answers here (include relevant dates):

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4. Have you ever had, or do you currently have, any of the following *eye, ear, nose, mouth or throat conditions*:
- |   |                    |
|---|--------------------|
| a. Vision problems?   | Y / N / Don’t Know |
| (1.) Wear contacts, eyeglasses or protective eye wear? (Circle which type.) | Y / N / Don’t Know |
| b. Hearing loss or problems?  | Y / N / Don’t Know |
| (1.) Wear hearing aides or implants?  | Y / N / Don’t Know |
| c. Nasal fractures or frequent nose bleeds?                                 | Y / N / Don’t Know |
| d. Wear braces, retainer or protective mouth gear?                          | Y / N / Don’t Know |
| e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)? | Y / N / Don’t Know |

Explain all “yes” answers here (include relevant dates):

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5. Have you ever had, or do you currently have, any of the following *neuromuscular/orthopedic conditions*:
- |   |                    |
|---|--------------------|
| a. Numbness, a “burner”, “stinger” or pinched nerve”      | Y / N / Don’t Know |
| b. A sprain?  | Y / N / Don’t Know |
| c. A strain?  | Y / N / Don’t Know |
| d. Swelling or pain in muscles, tendons, bones or joints? | Y / N / Don’t Know |
| e. Dislocated joint(s)?                                   | Y / N / Don’t Know |
| f. Upper or lower back pain?                              | Y / N / Don’t Know |
| g. Fracture(s), stress fracture(s), or broken bone(s)?    | Y / N / Don’t Know |
| h. Do you wear any protective braces or equipment?        | Y / N / Don’t Know |

Explain all “yes” answers here (include relevant dates):

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6. Have you ever had or do you currently have any of the following *general or exercise related conditions*:
- |   |                    |
|---|--------------------|
| a. Difficulty breathing?  | Y / N / Don't Know |
| (1.) During exercise?   | Y / N / Don't Know |
| (2.) After running one mile?  | Y / N / Don't Know |
| (3.) Coughing, wheezing or shortness of breath in weather changes?              | Y / N / Don't Know |
| (4.) Exercise-induced asthma?   | Y / N / Don't Know |
| i. Controlled with medication? (specify _____)                                  | Y / N / Don't Know |
| ii. Experience dizziness, passing out or fainting?                              | Y / N / Don't Know |
| b. Viral infections (e.g. mono, hepatitis, Coxsackie's virus)?                  | Y / N / Don't Know |
| c. Become tired more quickly than others?                                       | Y / N / Don't Know |
| d. Any of the following skin conditions:  |                    |
| (1.) Cold sores/herpes, impetigo, MRSA, ringworm, warts?                        | Y / N / Don't Know |
| (2.) Sun sensitivity?   | Y / N / Don't Know |
| e. Weight gain/loss (of 10 pounds or more)?                                     | Y / N / Don't Know |
| (1.) Do you want to weight more or less than you do now?                        | Y / N / Don't Know |
| f. Ever had feelings of depression?   | Y / N / Don't Know |
| g. Heat-related problems (dehydration, dizziness, fatigue, headache)?           | Y / N / Don't Know |
| (1.) Heat exhaustion (cool, clammy, damp skin)?                                 | Y / N / Don't Know |
| (2.) Heat stroke (hot, red, dry skin)?  | Y / N / Don't Know |
| (3.) Muscle cramps?   | Y / N / Don't Know |
| h. Absence or loss of an organ (e.g. kidney, eyeball, spleen, testicle, ovary)? | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

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7. Females only:

Age of onset of menstruation: \_\_\_\_\_ How many menstrual periods in the last twelve (12) months? \_\_\_\_\_  
 How many periods missed in the last twelve (12) months? \_\_\_\_\_

8. Males only:

Have you had any swelling or pain in your testicles or groin? \_\_\_\_\_ Y / N / Don't Know

<b>PARENT/GUARDIAN SIGNATURE</b>
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I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

\_\_\_\_\_  
 Signature, Parent/ Guardian or Student Age 18

\_\_\_\_\_  
 Date of Signature

**THIS COMPLETED AND SIGNED HEALTH HISTORY MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE MEDICAL EXAM.**