

PHYSICAL EXAM (To be completed by a physician or a nurse practitioner/physicians assistant)

Name: _____ Date: _____ Age: _____ Date of Birth: _____

Preferred Name: _____ Preferred Pronoun: _____

Address: _____ State: _____ Zip: _____

Height: _____ Vision: R: _____/_____ corrected ☐ / uncorrected ☐ Glasses? Yes ☐ No ☐Weight: _____ L: _____/_____ corrected ☐ / uncorrected ☐ Contacts? Yes ☐ No ☐

Pulse: _____ Blood Pressure _____/_____ Hearing: _____

	Normal	Abnormal	Comments
Eyes, Ears, Nose, Throat, Mouth & Teeth			
Neck, Thyroid			
Cardiovascular			
Chest & Lungs			
Abdomen			
Skin			
Genitalia-Hernia			
Testicular Exam			
Musculoskeletal: ROM, strength, etc.			
neck <input type="checkbox"/> shoulders <input type="checkbox"/> arms <input type="checkbox"/>			
hands <input type="checkbox"/> back <input type="checkbox"/> hips <input type="checkbox"/>			
knees <input type="checkbox"/> feet <input type="checkbox"/> legs <input type="checkbox"/>			
Neurological			
Date of last gynecological exam:			
Pap smear date & result:			
Breast Exam			

BELOW IS MANDATORY ONLY FOR **INTERCOLLEGIATE ATHLETES** – MUST BE COMPLETEDSICKLE CELL TRAIT: Positive _____ Negative _____ Unknown Status _____
(must be screened or sign waiver)

*Attach lab result of sickle cell trait screening (if available) or signed UNH Sickle Cell Waiver form

*The NCAA encourages ALL Intercollegiate athletes to be aware of their sickle cell trait status

*Waiver form available at: http://unhwildcats.com/Athletic_Training/Athletic_Training_home_page

- Does this applicant use tobacco products (cigarettes, cigars, chew, snuff or electronic cigarettes)? Yes ☐ No ☐
If yes, have you discussed the risk? Yes ☐ No ☐
- Has education about the use of alcohol, steroids, dietary supplements and other drugs, including misuse/abuse of prescription medication, been offered to this applicant? Yes ☐ No ☐
- Have you discussed safer sex issues with this applicant? Yes ☐ No ☐

Please comment on whether further evaluation or care is needed: _____

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):

Recommendations for Physical Activity: Exercise programs & use of fitness equipment.
Unlimited ☐ Limited ☐

Intercollegiate & Recreational Sports: Is this applicant capable of participating in a full program of college study, including participation in intercollegiate sports/intramural or club sports?
Yes ☐ No ☐

☐ Cleared after completing evaluation/rehabilitation for: _____

Recommendations: _____

Practitioner's Signature: _____ Date: _____

Please print name & address: _____

Telephone: _____

Return original to:

UNH Health Services
4 Pettee Brook Lane
Durham, NH 03824
Telephone: (603) 862-9355

If participating in Division I Intercollegiate Sports, please mail a copy of the physical assessment form to:

UNH Athletic Training
145 Main St., Field House
Durham, NH 03824

If participating in Club Sports, please mail a copy of the physical assessment form to:

Sport Club Coordinator
128 Main St., Hamel Center
Durham, NH 03824

STUDENT: I give consent for this form to be copied and released to the Athletic or Club Sports Department upon request. (Please complete in case permission is needed at a later date.)

Signature: _____ Date: _____