PRE-PARTICIPATION EVALUATION FORM

ELITE ATHLETES

E.F.S.M.A.

Sports Medicine Centre

Country

Date

PRE-PARTICIPATION EVALUATION FORM

Questionnaire to be completed by the athlete before physician's evaluation

Surame		**First Name**	
Date of Birth		**Gender**	
Team/Sports Club			
Sport/Position on the Field			
Phone Number		**E-mail**	

SECTION 1 - HEALTH STATUS

ATHLETE'S HISTORY FORM:

Please answer ALL the following questions below. Give details to ALL "YES" answers

No.	Family Medical History	Yes	No
1.	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death?		
2.	Has any family member or relative had a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome or cathecholaminergic polymorphic ventricular tachycardia (CPVT)?		
3.	Has any family member or relative had a pacemaker or implanted defibrillator before age 35?		
4.	Has any family member or relative had high blood pressure?		
5.	Has any family member or relative had unexplained seizures?		
6.	Has any family member or relative had diabetes?		

Please explain "YES" answers below:

SECTION 1 - HEALTH STATUS ... cont

No.	Personal Medical History	Yes	No
1	Has a doctor ever denied or restricted your participation in sports for any reason?		
2	Do you have a history of the following?		
	Fainting/dizziness/pass out during or after exercise?		
	Respiratory Problems (pneumonia, bronchitis, sinus problems)?		
	Chest discomfort during exercise?		
	Asthma or Wheezing? If yes, are you on medication or inhaler? Please specify		
	Attention Deficit Disorder or Attention Deficit-Deficit Hyperactivity?		
	Heart disease?		
	Chronic Skin Disease (e.g. eczema, psoriasis)?		
	Hepatitis/Yellow Jaundice/Kidney/Bladder Disease? Abdominal Issues, Digestive Tract Disease (ulcer, colitis, etc.) or Hernia?		
	Frequent or Severe Headache (migraine)?		
	High Blood Pressure/Cholesterol?		
	Depression or Anxiety?		
	Speech, Hearing, or Vision Problems?		
	Sexually Transmitted Disease or HIV?		
	Cancer (skin, thyroid, etc.)?		
	Thrombophlebitis or Blood Clots?		
	Thyroid, Diabetes or other Endocrine Disorder?		
	Other medical illnesses?		
3	Have you ever been knocked unconscious?		
4	Have you ever had a head injury of any kind?		
5	Have you ever had a seizure, convulsions or epilepsy?		

SECTION 1 - HEALTH STATUS ... cont

No.	Personal Medical History ... cont		Yes	No
6	Do you have an allergy to any of the following?			
	Drug or medicine (over the counter/prescribed)			
	Foods			
	Insect or animals			
	Plants, grasses, pollen, dust, other. Please specify			
7	Are you on any medication or regular treatment? (Including birth control pills, insulin, allergy shots or pills, asthma inhalers, epilepsy medication, anti-inflammatory medication, supplements of any kind. etc.) - Please Specify			
	Medication	**Dose**	**Frequency of use**	
	1.			
	2.			
	3.			
	4.			
	5.			
9	Have you ever had disordered eating?			
10	How many hours do you sleep per night?			
11	Do you consume nutritional supplements?			
12	Have you ever passed out or nearly passed out during exercise?			
13	Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?			
14	Does your heart ever race, flutter in your chest or skip beats during exercise?			
15	Do you get light-headed or feel shorter of breath than your friends during exercise?			
16	Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint or tendon?			
17	Do you wear contact lenses during practice or competition?			
18	Do you drink alcohol? If so, how often and how much?			
19	Do you smoke? If so, how often and how much?			
20	Do you have any ongoing medical issues or recent illness?			
21	Have you ever required surgery for any medical illness or injury?			

SECTION 1 - HEALTH STATUS ... cont

No.	Personal Medical History ... cont	Yes	No
	FEMALE ONLY		
22	Have you ever had a menstrual period?		
23	How old were you when you had your first menstrual period?		
24	When was the most recent menstrual period?		
25	How long does a period last? (on average)		
	In the past 12 months:		
26	Have you had trouble with heavy menstrual bleeding?		
27	Have you had bleeding between periods?		
28	Have you had menstrual cramps or pain which affected your school or athletic performance?		
29	Have you had any discharge from your vagina?		
30	Are you taking birth control pills?		
31	Have you ever been pregnant?		
	MALE ONLY		
32	Were you born with two normal testicles?		
33	Have you ever had surgery to remove or repair a testicle?		

Please explain “YES” answers below:

Do you have any other conditions, illnesses, etc. that should be reported?

SECTION 2 - TRAINING HISTORY

Sports training history			
Years in sports		**Last training**	
Best performance		**Next goals**	
Training Information			
Frequency per week		**Volume/duration of training per week/hours**	
Athletic peak performance		**Altitude training (duration, location)**	
Diagnosis of overreaching or overtraining			
Daily recovery			
Personal motivation for training	**Low**	**Medium**	**High**
Other Detail			

By signing this form, I acknowledge that I have answered all the questions truthfully and have given details to the best of my knowledge.

NAME OF ATHLETE	
SIGNATURE OF ATHLETE	

If under 18 years old:

SIGNATURE OF PARENT / LEGAL GUARDIAN	

SECTION 3 HEALTH CONDITION

MEDICAL COMPLAINTS: Symptoms and signs, aches or pains

The Physical Assessment			
		Normal	**Abnormal**
Dermatological condition Skin and membranes			
Lymph nodes thyroid gland			
Musculoskeletal system	Symmetry in joint range of movement, flexibility, strength test of the major muscle groups and balance test		
Respiratory system (percussion, breath sounds, murmurs)			
Cardiovascular system	HR (after 5min rest): _____ /min Blood pressure in supine position: Right arm ___/___ mmHg Left arm ___/___ mmHg		
Heart examination (auscultation standing, palpation, valsalva M., delay in femoral pulses)			
12-lead resting ECG (digital recording, software supported)			
Abdominal examination	Inspection Palpation Percussion Auscultation Gastrointestinal symptoms during exercise **Yes** **No**		
Neurological evaluation			
Surface EMG (optional)			
Ophthalmological Examination (Eyelids, lens, visual acuity, colour blind test, conjunctiva, anterior chamber)	Right eye Left Eye		

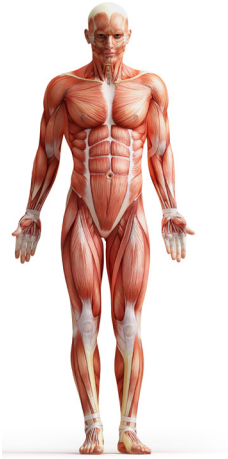
SECTION 3 HEALTH CONDITION ... cont

The Physical Assessment ... cont						
Fill in if you have lens prescription						
Right						**BIFOCAL** **TRIFOCAL** **SUN GLASSES** **TINT** **CASE HARDEN**
Left						
Reading						
Addition						
ENT examination	Nose					
	Throat					
	Ears					
	Hearing examination					

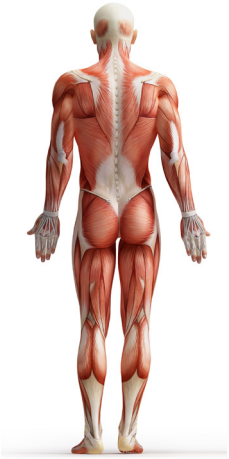
Psychological Assessment

Laboratory Tests			
Blood samples			
Urine samples			

Anthropometry



Spine	
Sagittal plan	
Front plan	
Upper limbs	
Lower limbs	



SECTION 3 HEALTH CONDITION ... cont

Biometrics							
Height (cm)		Weight (kg)		The height standing (cm)		Wingspan (cm)	
Biacromial diameter		Bitrochanteric diameter		Anterior thoracic - diameter		Transverse thoracic - diameter	
Evaluations:							
Chest perimeter on rests		Chest perimeter in inspiration		Chest perimeter in expiration			
Chest elasticity:							
Evaluations / thoracic elasticity:							
Joints perimeters	Wrist joint		Knee joint		Ankle joint		
Mobility							
Body composition analysis (Air Displacement Plethismography or whole-body densitometry)							
Diagnosis (Anthropometry and Nutritional Status)							

Functional and Exercise Capacity
1. CARDIO-PULMONARY EXERCISE TESTING CPET- **Digital recording, detailed documentation on a separate sheet, incl. parameters:** Vo2max, HR max, Heart Rate Reserve (HRR) BP max, Oxygen pulse (O2 Pulse), Oxygen saturation (SpO2), Breathing reserve (VE/MVV), Ventilator equivalents for oxygen (VE/VO2) and carbon dioxide (VE/VCO2), End-tidal CO2 partial pressure (PETCO2), Ventilators thresholds - (VT1, VT2), RMR
2. Lactate analysis
3. ANAEROBIC Exercise Capacity Assessment (optional one of): **- Wingate test** **- Total work performed 45 s** **- Ortojump**

SECTION 3 HEALTH CONDITION ... cont

Diagnosis Exercise Capacity	
Medical - Sports Recommendations	
Nutrition	
Ergogenic Aids	
Recovery	
Other	

SECTION 4 - CONCLUSIONS

Medical Eligibility form	Yes	No
Medically eligible for all sports without restriction		
Medically eligible with recommendation for further treatment or evaluation		
Not medically eligible for sport performance		

Name of the Examining Physician	
Address:	
Phone no:	
Email:	
Signature:	