

# PRE-PARTICIPATION EVALUATION FORM RECREATIONAL ATHLETES



Sports Medicine Centre

Country

Date



## PRE-PARTICIPATION EVALUATION FORM

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

<b>Surame</b>		<b>First Name</b>	
<b>Date of Birth</b>		<b>Gender</b>	
<b>Physical Activity</b>			
<b>Phone Number</b>		<b>E-mail</b>	

### SECTION 1 - HEALTH STATUS

Please answer ALL the following questions below.

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), channelopathy: long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia (CPVT)		
3.	Has any family member or relative had a pacemaker or implanted defibrillator?		
4.	Has any family member or relative had hypertension?		
5.	Has any family member or relative had unexplained seizures?		
6.	Has any family member or relative had diabetes?		

Please explain "YES" answers below:


# PRE-PARTICIPATION EVALUATION FORM



## SECTION 1 - HEALTH STATUS ... cont

No.	Personal Medical History	Yes	No
1	Do you have any ongoing medical issues or recent illness?		
2	Are you on any cardiac treatment?		
3	Do you have a history of the following?		
	Fainting/dizziness/ pass out during or after exercise?		
	Respiratory Problems (pneumonia, bronchitis, sinus problems)?		
	Chest discomfort or dyspnoea during exercise?		
	Asthma or Wheezing? If yes, are you on any medication or inhaler? Please specify		
	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 (> 140/90 mmHg for adults) High level of Cholesterol/abnormal lipid profile?		
	Depression or Anxiety?		
	Speech, Hearing Problems Vision Problems?		
	Sexually Transmitted Disease or HIV/ AIDS?		
	Cancer (if Yes please provide details)		
	Thrombophlebitis or Blood Clots?		
	Diabetes, Thyroid, or any other Endocrine Disorder?		
	Other illnesses?		
4	Have you ever been knocked unconscious?		
5	Have you ever had a head injury of any kind?		
6	Have you ever had a seizure, convulsions or epilepsy?		
7	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.		

# PRE-PARTICIPATION EVALUATION FORM



## SECTION 1 - HEALTH STATUS ... cont

No.	Personal Medical History ... cont		Yes	No
8	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.)			
	<b>Medication</b>	<b>Dose / Frequency of use</b>	<b>How long have you been taking this drug?</b>	
	1.			
	2.			
	3.			
	4.			
	5.			
9	Do you consume nutritional supplements?			
10	Are you on special diet? Do you avoid certain type of foods? If yes, why? Please specify			
11	Have you ever had an eating disorder or disordered eating?			
12	Post exercise recovery?			
13	How many hours do you sleep per night?			
14	Have you ever passed out or nearly passed out during exercise?			
15	Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?			
16	Do you ever feel that your heart ever was working irregularly during exercise?			
17	Do you get light-headed or feel shorter of breath than your friends during exercise?			
18	Has a physician ever denied or restricted your participation in sports for any health problems?			
19	Have you been hospitalised in the past two years?			
20	Have you ever required surgery for any medical illness or injury?			
21	Do you smoke? If so, how often and how much and how long?			
22	Do you drink alcohol? If so, how often (per week), how much and what kind of alcohol do you drink? Have you ever used marijuana or any similar drugs?			
23	<b>FEMALE ONLY</b>			
	How old were you when you had your first menstrual period?			
	When was your last menstrual period?			
	How many menstrual periods have you had in the last 12 months?			
	Are you taking birth control pills?			
24	What vaccinations did you have in the last 2 years: against the flu, COVID-19, pneumonia etc?			

# PRE-PARTICIPATION EVALUATION FORM

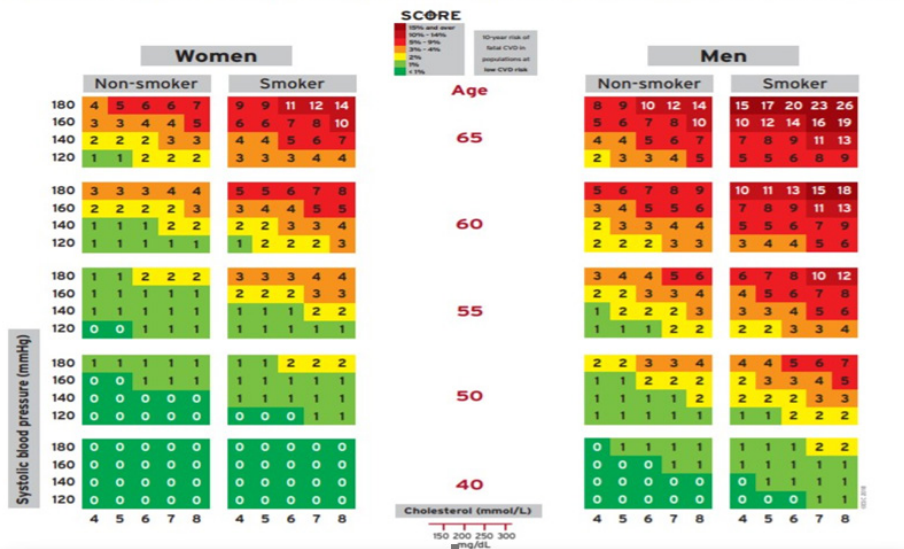
## SECTION 1 - HEALTH STATUS ... cont

Please explain "YES" answers below:

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

## SCORE - European Low Risk Chart

10 year risk of fatal CVD in low risk regions of Europe by gender, age, systolic blood pressure, total cholesterol and smoking status



The European score can also be applied by the ASCVD Score.

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	
SIGNATURE	

## SECTION 2 - TRAINING HISTORY

Sports training history					
Years (months) in sports		Last training			
Training Information according to the acronym FITT: frequency per week, intensity, type and time					
Personal motivation for training	Low		Medium		High
Training Intensity The Borg 20 Point Scale – Rate of Perceived Exertion (RPE)					
RPE	Description		RPE	Description	
6	None		14	Somewhat hard	
7	Very, very light		15	Hard	
8	Very, very light		16	Hard	
9	Very light		17	Very hard	
10	Very light		18	Very hard	
11	Fairly light		19	Very, very hard	
12	Fairly light		20	Very, very hard	
13	Somewhat hard				

## SECTION 3 HEALTH CONDITION

### COMPLAINTS: Symptoms and signs, aches or pains

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### Physical Evaluation

#### Examination

BP:     /     (     /     ) mmHg                      HR:     beats/min.

Femoral pulse

#### Medical

Normal

Abnormal

**Appearance:** Any murmur or irregularity by auscultation    Marfan stigmata (kyphoscoliosis, high arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse, aortic insufficiency), other

Eyes, ears, nose, throat

Vision:  
R 20/  
L 20/  
Corrected

Yes

No

Lymph nodes

Heart

Murmurs (auscultation standing, auscultation supine)  
Valsalva maneuver  
Delay in femoral pulses

12-lead resting ECG

(digital recording, software supported)

**Abdomen** (Inspection, Palpation, Percussion, Auscultation)

Gastrointestinal symptoms during exercise

Yes

No

**Skin** e.g. Herpes simplex virus, lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA) or tinea corporis

#### Musculoskeletal

Normal

Abnormal

Neck

Back

Shoulder and arm

## SECTION 3 HEALTH CONDITION ... cont

### Physical Evaluation ... cont

Musculoskeletal	Normal	Abnormal
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional Double leg squat test, single leg squat test, box drop or step drop test		

### Laboratory Tests (optional)

Blood and Urine samples

### Biometrics

Height (cm)		Weight (kg)		BMI		Abdominal perimeter (cm)	
Waist circumference (cm);		Hip circumference (cm),		WHR indicator			
Body composition (Bioelectrical Impedance Analysis) optional							

### Diagnosis Anthropometry and Nutritional Status



## SECTION 3 HEALTH CONDITION ... cont

### Exercise Capacity

Optional one of (see separate sheet):

#### CARDIO-PULMONARY EXERCISE TESTING (CPET)

**Ergometry** to exhaustion (standardised); Measurements:

**Achieved peak workload** (calculate V02 max, V02 max/kg and MET's by means of algorithm e.g. Myers et al.);

**Heart rate**, incl. HR immediately after 1 and 3 min after end of exercise;

**Blood pressure** (rest and during exercise, at peak of exercise);

**ECG: rest and exercise** (recording continuously

COOPER Test or other Exercise test

**SPORTS RECOMMENDATIONS** according to EFSMA tables ([www.efsma.org](http://www.efsma.org))  
by means of exercise prescription for health (FITT)

F  
I  
T  
T

Nutrition (optional)

## SECTION 4 - CONCLUSIONS & MEDICAL ELIGIBILITY FORM

Medical Eligibility form	Yes	No
Medically eligible for leisure time activities without restriction		
Eligible for training with special medical monitoring or medical rehabilitation		
Not medically eligible pending further examination		

### Examining Physician and Medical Centre Stamp

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