SMCCCD Pre-Participation Sports Screening

This is not a substitute for a regular physical exam by your family doctor

Print Last Name __________________________ Print First Name _________________ G# _________________ Sport ______

This Exam must be signed off by an MD or DO

Exams signed off by any other health care professional will not be accepted!

Students complete page 1 and 2 of this sports screening exam. All questions must be answered.

MD or DO must complete and sign page 3 of this sports screening exam.

1. FAMILY MEDICAL HISTORY: Check "Yes" or "No" for all questions and explain all "Yes" responses in the space provided.

Yes No Has anyone in your family ever died for no apparent reason? Relationship to you: ________________

Yes No Has any family member/blood relative died of heart problems or of sudden death before age 50? Relationship to you ____

Yes No Does anyone in your family have any heart problems, conditions (i.e. hypertrophic cardiomyopathy, dilated cardiomyopathy, Long QT syndrome, Marfans' syndrome, Cardiac Arrythmias) or has had heart surgery? Explain _________
____

2. ATHLETE'S MEDICAL HISTORY: : Check "Yes" or "No" for all questions and explain all "Yes" responses in the space provided.

When was your last physical exam that included blood pressure and a doctor listening to your heart & lungs? Date ______________

Yes No Have you ever had a medical illness, injury, or surgery that kept you from participating in practice or competition?
If Yes, explain: ____
Injury/Illness/Surgery was: ____________________________ Year_____Time missed: Days ___ Weeks ____Months ______

Yes No Were you born without or are you missing any of the following? ___ Kidney ___ Eye ___ Testicle ___ Other Organ

Yes No Are you allergic to: ___ Foods ______ Stinging Insects ______ Environmental Agents/Pollen ____ Medication ________

Yes No Have you ever had to stay overnight in the hospital as a patient? Explain ____

Yes No Have you ever had any surgery for any medical condition? Explain ____

Yes No Have you ever passed out or nearly passed out **during** exercise? Why? __ Medical Illness ___Conditioning __ Heat

Yes No Have you ever passed out or nearly passed out **after** exercise? Why? ___ Medical Illness ___Conditioning ___ Heat

Yes No Do you get more easily tired or fatiqued than your teammates during or after exercise? __ Med Illness __ Cond. __Heat

Yes No Have you ever had chest discomfort, pain or pressure during exercise? ___Mild Exercise _ Moderate Ex. ___ Strenous Ex

Has a doctor ever asked that you complete, or have you had, any of the following tests:

Yes	No	Test	Requested	Completed	Year	For what reason?
		X-Ray				
		MRI				
		CT Scan				
		Bone Scan				
		EMG (Nerve Test)				
		EKG (Heart test)				
		Stress EKG				
		Echocardiogram				
		Stress Echocardiogram				
		Halter Monitor				

Yes	No	Medication/Supplement Use	Name of Medication	Reason/Condition		Name of Medication	Reason/Condition
		Over-the-counter Medications					
		Prescription Medications					
		Prescribed Creams/Ointment					
		Inhalers					
		Supplements for Weight Gain					
		Supplements for Weight Loss					
		Anabolic Steroids/HGH					

Yes No Do you use or have you ever used recreational drugs? ___ Daily ___1x/week ___< 1x/week ___1x/month

Yes No Do you or have you ever consumed alcoholic drinks? ___ Daily ___ 1x/week ___<1x/week ___ 1x/month

Yes No Do you use tobacco? ___ Cigarettes ___Cigars ___ Smokeless Dip/Chew __Daily __1x/wk __<1x/wk __1x/mo.

Print Last Name ____________________________**Print First Name** ________________**G#** ________________ **Sport** __________

YES	NO	WOMEN ONLY	
		Have you been pregnant?	Year(s)
		Are you pregnant now?	How many months?
		Date of first menstrual cycle	Month _____ Year _____
		Longest time between periods	Days _____ Months _____
		No periods since:	Month _____ Year _____
		Menstrual irregularity / cramps	Medication __________________________
		Are you taking Birth Control Pills	

2a. ATHLETE'S MEDICAL HISTORY – Have you ever had any of the following symptoms?

Yes	No	Year	Symptoms		Yes	No	Year	Symptoms
			Dizzyness					Chest Pain
			Fainting/Near Fainting					Shortness of Breath
			Chest Tightness/Pressure					Wheezing
			Irregular Heart Beats					Headaches
			Abdominal Pain					Heart Skips Beats

2b. ATHLETE'S MEDICAL HISTORY – Have you ever had any of the following conditions?

Yes	No	Year	Condition		Yes	No	Year	Condition
			Rhumatic Fever					Asthma / Exercise Induced Asthma
			Mononucleosis					Bronchitis
			Jaundice					Pneumonia
			Cancer					Pneumothorax
			Kidney Disease					
			Thyroid Disease					Heart Murmur
			Thyroid Disease					Cardiomyopathy
								Marfan's Syndrome
			Heat Cramps/Illness					Sickle Cell: Disease ___ Trait ___
			Dehydration					Heart Infection - Myocarditis
			Heat Exhaustion/Stroke					Hemophilia
								Anemia
			Crohn's Disease					High Blood Pressure
			Bladder/Bowel problems					HIV ___ Aids ___
			Anorexia/Bulimia					High Cholesterol
			Ulcers					Diabetes: Type 1 __ Type 2 __
			Apendicitis/Apendectomy					Blood Sugar: High ___ Low ___
			Hernia					Hepatitis: A ___ B ___ C ___
			Impetigo					Visual Impairment
			Herpes Zoster					Hearing Impairment
			Herpes Simplex (cold sores)					
			Tinea Corporis (ringworm)					Concussion or Knocked Out
			Tinea Cruris (jock itch)					Migraine Headaches
			Tinea Pedis (athletes foot)					Epilepsy
			Folliculitis					Seizures
			MRSA					

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YES	NO	Don't Know	IMMUNIZATION RECORD	Year
			Tetanus	
			Hepatitis A	
			Hepatitis B	

Please list all medical illness or conditions that kept you from participating in any practice or competition, what year, time lost, and outcome:

Condition	Year	Time Lost	Outcome

3. **ATHLETE'S MUSCULOSKELETAL HISTORY:** Have you **ever** had any of the following?

Yes	No	Year	Injury		Yes	No	Year	Injury
			Muscle Strain/Pull					Head Injury
			Ligament Sprain/Injury					Neck Pain/Injury
			Deep Bruise/Contusion					Upper Back Pain/Injury
			Fracture					Lower Back Pain/Injury
			Stress Fracture					Rib or Chest Pain/Injury
			Nerve Injury/Stinger					Shoulder Pain/Injury
			Meniscus Injury					Elbow Pain/Injury
			Cartilage Injury					Forearm Pain/Injury
			Labral Injury					Wrist Pain/Injury
			Tendonitis/Tendinopathy					Hand Pain/Injury
			Shin Splints					Finger Pain/Injury
								Thumb Pain/Injury
			Surgery					Hip Pain/Injury
			Numbness due to injury					Thigh Pain/Injury
			Weakness due to injury					Knee Pain/Injury
								Lower Leg Pain/Injury
			Crutches					Ankle Pain/Injury
			Splint/Sling					Foot Pain/Injury
			Brace					Toe Pain/Injury

Please list all injuries that kept you from participating in any practice or any competition?

Injury	Year	Time Lost	Outcome

I certify that all the information I have completed regarding Family Medical History, Athlete's Medical History, Medication/Supplement Use, Immunization Record, and Musculoskeletal History is complete and accurate to the best of my knowledge.

Athlete's Signature ____ Date_____________________

Parent's Signature (if athlete is a minor under 18 years) ________________________________ Date________

Print Last Name: ___________________________ First Name_____________________ G#____________________ Sport:______________

MD or DO must certify and sign off this section. Doctor, please check each item with your finding and provide a final disposition at the bottom of the form.

4. MEDICAL EXAMINATION Check each item giving details in space to right if abnormal or noteworthy.

Medical Examination	Normal	Abnormal
1. Blood Pressure (Seated) Systolic_______/_______ Diastolic		
2. Resting Heart Rate (required) BPM:		
3. Eye Test (required) Left Eye: 20/ Right Eye: 20/		Vision tested with ☐Contact Lenses ☐Glasses
4. Height: _____ ' _____ " Weight:_______		
5. General Appearance (fitness, body fat)		
6. HEENT (pupils, ears, eyes, nose, mouth, teeth, throat)		
7. Chest (chest wall and breath sounds)		
8. Cardiac auscultation supine and standing (murmur)		
9. Cardiac (Pulses and rhythm)		
10. Abdomen (liver, spleen, masses)		
11. Skin (rash, jaundice)		
12. Neurologic (CNS, DTR's, sensations)		
13. Geniturinary (male only: hernia, testes)		
14. BMI: ________ or % BF: ____________ (Optional)		

5. MUSCULOSKELETAL EXAMINATION: Check each item giving details in space to right if abnormal or noteworthy.

Musculoskeletal Exam: (Grade abnormal joint laxity tests on a 0-3+ scale)	**Normal**	**Abnormal**
1. Spine (deformity, tenderness, motion, strength, stability)		
a. Cervical (facet dysfunction, disk injury, radiculopathy, stingers)		
b. Thoracic (kyphosis, scoliosis)		
c. Lumbar (spondylolysis, spondylolisthesis, facet dysfunction, disk injury)		
2. Upper Extremity (deformity, tenderness, motion, strength, stability)		
a. AC/ SC Joint/Clavicle (AC separation, clavicle dislocation/instabillity)		
b. Shoulder (rotator cuff, labrum, instability, impingement)		
c. Elbow (UCL tears, tendonitis, loose bodies, Little League elbow)		
d. Wrist (carpal tunnel, tendinitis, instability)		
e. Hand		
f. Thumb (De Quervain's, instability, tenderness, motion)		
g. Fingers (Mallet or Jersey Finger, Swan Neck or Boutineer Deformity		
3. Lower Extremity (deformity, tenderness, motion, strength, stability)		
a. Hip (deformity, joint pain, range of motion, hip flexors, labrum)		
b. Leg (Hamstrings, Quadriceps)		
c. Knee (MCL, LCL, ACL, PCL, Meniscus)		
d. Lower leg (MTSS, Achilles Tendon)		
e. Ankle (talar tilt, anterior drawer)		
f. Foot (supination, pronation, pes cavus, pes planus)		
g. Toes (hallux valgus, hammer toes, bunions)		

Finding/Problems	Recommendations (Prevention/Treatment)
1	
2	
3	

MEDICAL AND MUSCULOSKELETAL DISPOSITION

_______ Cleared for collision/contact/non-contact sports

_______ Conditional Participation, limited to: ____

_______ No participation until:____

_______ No participation in any sport because of:____

✱✱Physician's Signature Required: ____ Date: :____/_____/_____

Print Physician's Name:____

Physician's Phone if not on office stamp: ( ) -

M.D. Office Stamp Required