SMCCD Pre-Participation Sports Screening Update

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

Last Name_____________________First Name_______________G#__________________Sport________

In order to update our physical screening records, please review the following sections on your previous years' physical screening form and make changes where appropriate.

1. **FAMILY MEDICAL HISTORY**: Are there any changes to your answers under this section?
   YES NO _____initials

2. **ATHLETE'S MEDICAL HISTORY**: Are there any changes to your answers under this section?
   YES NO _____initials

MEDICATION/SUPPLEMENT USE: Are there any changes to your answers under this section?
YES NO _____initials

WOMEN ONLY SECTION: Are there any changes to your answers under this section?
YES NO N/A (I am male) _____initials

2.a/2.b **ATHLETE'S MEDICAL HISTORY**: Are there any changes to your answers under this section?
YES NO _____initials

IMMUNIZATION RECORD: Are there any changes to your answers under this section?
YES NO _____initials

3. **MUSCULOSKELETAL HISTORY**: Are there any changes to your answers under this section?
   YES NO _____initials

Please explain any YES responses/changes below:

____
____
____
____
____
____

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