SMCCCD Pre-Participation Sports Screening

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

Print Last Name: _____ 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 Do you have a heart implant or monitor? If yes describe _____

☐ Yes ☐ No Has anyone in your family had a heart problem/condition and/or surgeries such as but not limited to: Check condition if known.

☐Coronary artery disease ☐Heart attack ☐Heart Murmur ☐Balloon Angioplasty ☐Near Fainting/Fainting/Passing out

☐Skipped Heart Beats ☐Chest Pain ☐Bypass surgery ☐High Blood Pressure ☐Shortness of breath/excessive/unexplained

☐Extra Heart Beats ☐ Heart defect ☐Heart Palpitations ☐Marfan's syndrome ☐Irregular Heart Rhythm/Arrhythmia

☐Dilated Cardiomyopathy ☐Angina ☐Hypertrophic Cardiomyopathy ☐Excessive fatigue associated with exercise

☐Diabetes ☐Other _____ ☐Other _____

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

☐ Yes ☐ No Has it been more than two years since you had a physical exam that included blood pressure and a doctor listening to your heart?

☐ Yes ☐ No Have you ever had a medical illness/injury/surgery that kept you from participating in practice or competition? If "yes" explain below:

Injury/Illness/Surgery was_____ Year_____ Amount of time missed: Days_____ Weeks_____ Months_____

☐ Yes ☐ No Are you allergic to: ☐Foods ☐Stinging Insects ☐Environmental agents/Pollen ☐Medications: List_____

☐ Yes ☐ No Do you use or have you ever used recreational drugs? ☐Never ☐Daily ☐Once/week ☐More than once/week ☐Once/month

☐ Yes ☐ No Do you use or have you ever used alcoholic drinks? ☐Never ☐Daily ☐Once/week ☐More than once/week ☐Once/month

☐ Yes ☐ No Do you ☐smoke cigarettes, ☐use dip/chew tobacco? ☐Never ☐Daily ☐Once/week ☐More than once/week ☐Once/month

☐ Yes ☐ No Have you ever passed out or nearly passed out **during** exercise? Why? ☐ Medical Illness ☐Conditioning ☐Heat related

☐ Yes ☐ No Have you ever passed out or nearly passed out **after** exercise? Why? ☐ Medical Illness ☐Conditioning ☐Heat related

☐ Yes ☐ No Do you get more easily tired or fatigued than your teammates during or after exercise? ☐Illness ☐Conditioning ☐Heat related

☐ Yes ☐ No Have you ever had chest discomfort, pain or pressure during exercise? ☐Mild Exercise ☐Moderate Exercise ☐Strenuous Exercise

☐ Yes ☐ No Has a doctor ever ordered or have you had a test for your heart? ☐EKG ☐Stress EKG ☐Halter Monitor ☐Echocardiogram ☐Stress Echo

☐ Yes ☐ No Have you ever been hospitalized, had surgery recommended or had surgery for a medical condition? Why and when? _____

☐ Yes ☐ No Were you born without or are you missing any of the following? ☐Kidney ☐Eye ☐Testicle ☐other organ:_____

Yes	No	**Medication/Supplement Use**	Name of Medication	Reason /Condition	Name of Medication	Reason/Condition
		Over the counter medications				
		Prescription medication/pills				
		Inhalers				
		Supplements (ie Creatine)				
		Weight loss medications				
		Laxatives/Diet pills				
		Anabolic steroids/HGH				
		Birth control pills				
		Topical ointments/creams				

Yes	No	**Women Only**	Date
		Are you pregnant?	How many months?_____
		Date of first menstrual cycle	Month_____ Year_____
		Longest time between periods	Days_____ Months _____
		No periods since	Month_____ Year_____

Yes	No	**Immunizations (**if known)	Year
		Tetanus	
		Hepatitis A	
		Hepatitis B	
		Hepatitis C	

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2. ATHLETE'S MEDICAL HISTORY (con't): Have you ever had any of the following symptoms or medical conditions?

Yes	No	Year	Condition	Yes	No	Year	Condition	Yes	No	Year	Condition
			Chest Pain				Chest Tightness				Bronchitis /Chronic Bronchitis
			Dizzyness				Chest Pressure				Dilated Cardiomyopathy
			IHSS				High Cholesterol				Hypertrophic Cardiomyopathy
			Rheumatic Fever				Heart Murmur				Shortness of Breath
			Heart Infection				Irregular Heart Beats				Long QT Syndrome
			Asthma/EIA				Heart Skips Beats				Marfan's Syndrome
			Wheezing				High Blood Pressure				Fainting☐ Nearly Fainting☐
			Pneumonia				Pneumothorax				Sickle Cell Disease☐ Trait☐
			Ulcers				Cancer				Severe Dehydration
			Heat Cramps/Illness				Heat Stroke				Diabetes: ☐Type 1 ☐Type 2
			Anemia				Abdominal Pain				Blood Sugar: ☐High ☐Low
			Headaches				Migraine headaches				Concussion/Knocked Out
			Seizures				Skull Fracture				Hepatitis: ☐A ☐B ☐C
			Mononucleosis				Anorexia/Bulimia				HIV☐ Aids☐
			Hernia				Kidney Disease				Menstrual Irregularity/Cramps
			Appendectomy				Pregnancy				Bladder/Bowel Problems
			Impetigo				Folliculitis				Tinea Corporis (ringworm)
			Herpes Zoster				Tinea Cruris (jock itch)				Herpes Simplex (cold sore)
			Hearing Impairment				Vision Impairment				MRSA
			Thyroid Disease				Jaundice				Crohn's Disease
							Hemophilia				

3. Musculoskeletal History: Have you ever had any of the following injuries, surgery, tests or used orthopedic supports for injuries?

Yes	No	Year	Injury	Explain	Yes	No	Year	Injury	Explain
			Muscle Strain/Pull					☐Knee Pain/Injury ☐Surgery	
			Ligament Sprain					Painful Kneecap	
			Deep Bruise/Contusion					Knee gives way or buckles	
			Joint Locking or Catching					☐Hip Injury ☐Surgery	
			Torn ☐Cartilage ☐Labrum					☐Shoulder Injury ☐Surgery	
			Tendonitis/Tendinopathy					☐Elbow Injury ☐Surgery	
			☐ Fracture ☐ Stress Fracture					☐Wrist Injury ☐Hand Injury	
			☐ Nerve Injury ☐ Stinger					☐Finger ☐Thumb Injury	
			☐MRI ☐CT Scan for:					Other Orthopedic Surgery for:	
			☐Bone Scan ☐EMG for:					Neck Pain/Injury	
			☐Crutches ☐Sling for:					Arm/Finger Numbness	
			☐Splint ☐Cast for:					Arm/Hand Weakness	
			☐Foot Injury ☐Toe Injury					Upper Back Injury	
			☐Ankle Injury ☐Achilles Injury					Low Back Pain/Injury	
			Shin Splints/MTSS					Leg/Foot Numbness	
			Inability to participate from injury					Leg/Foot Weakness	
			Rib/Chest Injury					Hemo/Pneumothorax	
			Skull Fracture/Injury						

I certify that all the information on all the pre-participation sports screening exams forms, I have filled out, including my family medical history, my medical and musculoskeletal history are complete and accurate to the best of my knowledge:

Athlete's Signature_____ Date:____/_____/_____

Parent's signature (if athlete is a minor under 18 y/o): _____ 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: ( ) -

Π M.D. Office Stamp Required