

## SMCCCD Pre-Participation Sports Screening

(\* Athlete completes & signs form. Parent/Legal Guardian must sign as well if student is under 18 years of age)

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

Print Full Name: \_\_\_\_\_ G# \_\_\_\_\_ Sport: \_\_\_\_\_

1. Musculoskeletal History: Have you ever had any of the following injuries? Check “Yes” or “No”. Explain all “Yes” answers below.

Yes	No	Injury	Year	Explain	Yes	No	Injury	Year	Explain
		Muscle Strain/Pull					Low Back Pain/Injury		
		Ligament Sprain					Leg/Foot Numbness		
		Deep Bruise					Leg/foot weakness from back		
		Joint Locking/Catching					Neck Pain/Injury		
		Torn cartilage/labrum					Skull Fracture /Injury		
		Tendonitis					Arm/Finger Numbness		
		Shoulder Injury					Arm/Hand weakness from neck		
		Elbow Injury					Foot Injury		
		Wrist Injury					Ankle Injury		
		Hand Injury					Toe Injury		
		Finger Injury					Knee Pain/Injury		
		Upper Back Injury					Painful Kneecap		
		Rib/Chest Injury					Shin splints		
		Hemo/Pneumothorax					Other:		

Explanations:

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2. Medical History: Have you ever had any of the following symptoms or medical conditions? Check “Yes” or “No” for all questions and explain all “Yes” responses below.

Yes	No		Yes	No		Yes	No		Yes	No	
		Chest Pain			Chest Tightness			High Blood Pressure			Irregular Heart Beats
		Dizziness			Chest Pressure			Shortness of Breath			Fainting/Nearly Fainting
		IHSS			High Cholesterol			Long QT Syndrome			Hypertrophic Cardiomyopathy
		Asthma/EIA			Heart Murmur			Marfan’s Syndrome			Dilated Cardiomyopathy
		Wheezing			Rheumatic Fever			Pneumonia			Bronchitis /Chronic Bronchitis
		Seizures			Headaches			Hemophilia			Concussion/Knocked Out
		Mononucleosis			Migraine headaches			Anorexia/Bulimia			Hernia
		Ulcers			Abdominal Pain			Appendectomy			Bladder/Bowel Problems
		HIV/Aids			Diabetes Type <input type="checkbox"/> 1 <input type="checkbox"/> 2			High/Low Blood Sugar			Kidney Disease
		Anemia			Sickle Cell Disease/Trait			Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C			Menstrual Irregularity/Cramps
		Heat Illness			Heat Cramps			Severe Dehydration			Pregnancy
		Impetigo			Folliculitis			Herpes Zoster			Herpes Simplex (cold sore)
		Cancer			Tinea Cruris (jock itch)			Tinea Pedis (athlete’s foot)			Tinea Corporis (ringworm)
		Jaundice			Thyroid Disease			Crohn’s Disease			Eye/Vision Problems

Explanations:

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Turn Over and fill out Page 2

3. Check "Yes" or "No" for all questions and explain all "Yes" responses below.

- Yes  No Has a doctor ever denied or restricted your participation in sports for any reason?
- Yes  No Has it been more than two years since you had a physical exam that included blood pressure and listening to your heart?
- Yes  No Are you allergic to any medications, pollens, foods, stinging insects or environmental agents?
- Yes  No Do you cough, wheeze or have difficulty breathing during or after exercise?
- Yes  No Have you ever used an inhaler or taken asthma medicine?
- Yes  No Are you presently taking any prescription or over the counter medications, pills or supplements?
- Yes  No Have you ever passed out or nearly passed out **during** exercise?
- Yes  No Have you ever passed out or nearly passed out **after** exercise?
- Yes  No Have you ever had excessive fatigue, associated with exercise?
- Yes  No Have you ever had discomfort, pain or pressure in your chest at rest or during exercise?
- Yes  No Does your heart race or skip beats at rest or during exercise?
- Yes  No Has your doctor ever told you that you have high blood pressure?
- Yes  No Has your doctor ever told you that you have a heart infection?
- Yes  No Has a doctor ever ordered a test for your heart?
- Yes  No Has anyone in your family ever died for no apparent reason?
- Yes  No Has anyone in your family had a heart problem / condition and/or surgeries (such as but not limited to a coronary artery disease, heart attack, heart murmur, heart defects, hypertrophic cardiomyopathy, dialated cardiomyopathy, angina, balloon angioplasty, bypass surgery, chest pains, heart palpitations, fainting or near fainting, passing out, high blood pressure, irregular, arrhythmic or extra heart beats, excessive or unexplained shortness of breath, excessive fatigue associated with exercise or any other history of heart problems)? If yes, explain their relationship to you.
- Yes  No Has any family member or blood relative died of heart problems or of sudden death before age 50?
- Yes  No Does anyone in your family have Marfan syndrom?
- Yes  No Have you ever been hospitalized?
- Yes  No Have you ever had an operation/surgery?
- Yes  No Were you born without or are you missing a kidney, an eye, a testicle or any other organ?
- Yes  No Have you ever had X-Rays, wore a cast, splint, sling, or used crutches?
- Yes  No Have you ever had any rashes, pressure sores, or other skin problems?
- Yes  No Have you ever had an injury/illness/medical problem that prevented you from participating in any practice or competition for more than one day?
- Yes  No Do you use or have you ever used  anabolic steroids,  alcoholic drinks,  recreational drugs or  other?
- Yes  No Do you use any tobacco products? If yes, how often? \_\_\_\_\_ times per day
- Yes  No Have you even taken or are you now taking over-the-counter medications to lose weight (diet pills or laxatives)? When? \_\_\_\_\_
- Yes  No Do you have an eating disorder?

When was your last tetanus shot? \_\_\_\_/\_\_\_\_/\_\_\_\_ (Optional)

**For women only:**

When was your first menstrual period? \_\_\_\_/\_\_\_\_/\_\_\_\_

What was the longest time between the periods? \_\_\_\_\_ days/months

Yes  No Are you pregnant?

Explanations:

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I certify that the above information is complete and accurate to the best of my knowledge:

Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent / Legal Guardian signature if athlete is under 18 years old: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Physical Screening by Medical Doctor (MD/DO only)

Print Name: \_\_\_\_\_ Exam Date: : \_\_\_\_/\_\_\_\_/\_\_\_\_

Eye Exam: Right Eye: \_\_\_\_/20 Left Eye: \_\_\_\_/20 (tested with  Contact Lenses  With glasses)

Blood Pressure (seated): \_\_\_\_/\_\_\_\_ Pulse: \_\_\_\_\_ Height: \_\_\_\_\_' \_\_\_\_\_" Weight: \_\_\_\_\_ % BF: \_\_\_\_\_(Optional)

**EXAMINATION** – Check each item giving details in space to right if abnormal or noteworthy.

Musculoskeletal Exam:	Normal	Abnormal
<b>Spine (deformity, tenderness, motion, strength, stability)</b>		
a. Cervical		
b. Thoracic		
c. Lumbar		
<b>1. Upper Extremity (deformity, tenderness, motion, strength, stability)</b>		
a. AC Joint/Clavicle		
b. Shoulder (rotator cuff, labrum, instability)		
c. Elbow		
d. Wrist		
e. Hand		
f. Thumb		
g. Fingers		
<b>Lower Extremity (deformity, tenderness, motion, strength, stability)</b>		
a. Hip		
b. Leg (hamstrings, quads, hip flexors)		
c. Knee (MCL, LCL, ACL, PCL, Meniscus)		
d. Lower leg (gastroc, achilles)		
e. Ankle (talar tilt, anterior drawer)		
f. Foot		
g. Toes		
<b>Medical Exam:</b>		
1. General Appearance (fitness, body fat)		
2. HEENT (pupils, ears, eyes, nose, mouth, teeth, throat)		
3. Chest (chest wall and breath sounds)		
4. Cardiac auscultation supine and standing (murmur)		
5. Cardiac (Pulses and rhythm,)		
6. Abdomen (liver, spleen, masses)		
7. Skin (rash, jaundice)		
8. Neurologic (CNS, DTR's, sensations)		
9. Genitourinary (male only: hernia, testes)		

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

**DISPOSITION**

- \_\_\_\_\_ Cleared for collision/contact/non-contact sports
- \_\_\_\_\_ Conditional Participation, limited to: \_\_\_\_\_
- \_\_\_\_\_ No participation until: \_\_\_\_\_
- \_\_\_\_\_ No participation in any sport because of : \_\_\_\_\_

Print Physician's Name: \_\_\_\_\_  MD  DO Please check

Physician's Signature: \_\_\_\_\_ Date: : \_\_\_\_/\_\_\_\_/\_\_\_\_

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

**II M.D. Office Stamp Required**