

Barça Residency Academy Pre Participation Physical



Name: _____ Date of Birth _____ Date of Exam: _____

Physician Reminders

- 1. Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
- 2. Consider reviewing questions on cardiovascular symptoms (Questions 5-16)

Examination		
Height _____ Weight _____		Male Female
BP ____ / ____ Pulse _____		Vision R 20/____ L 20/____ Corrected Y N
Medical	Normal	Abnormal Findings
Appearance Marfan stigmata (kyphoscoliosis, high arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/Ears/Nose/Throat Pupils Equal Hearing		
Lymph Nodes		
Heart* Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (MPI)		
Pulses Simultaneous femoral and radial pulse		
Lungs		
Abdomen		
Genitourinary (males only) **		
Skin HSV, Lesions suggestive of MRSA, tinea corporis		
Neurologic ***		
Musculoskeletal	Normal	Abnormal Findings
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional (Duckwalk, single leg hop)		

* Consider ECG, echocardiogram, and referral for abnormal cardiac history or exam
** Consider GU exam in a private setting. Having a third party present is recommended
*** Consider cognitive evaluation or baseline neuropsychiatrics testing if a history of significant concussion

Name of Physician (print/type)	Date:
Address:	
	Phone:
Signature of Physician: _____	

Barça Residency Academy Pre Participation Physical



Name: _____ Date of Birth _____ Date of Exam: _____

Sex: M | F Grade: _____ Age _____

Barça Residency Academy Pre Participation Physical

Note: This form is to be filled out by the patient and parent prior to seeing the physician.

Medicines & Allergies: Please list all of the prescription and over the counter medicines and supplements that you are currently taking:

Do you have any allergies (circle)? Y | N If Yes, please circle & identify specific allergy below

Medicines _____ Pollens _____ Food _____ Stinging Insects _____

Explain "Yes" answers below. Circle questions you don't know the answers to

General Questions	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions?		
3. Have you ever spent the night in hospital?		
4. Have you ever had surgery?		
Heart Health Questions about you	Yes	No
5. Have you ever passed out or nearly passed out DURING exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have heart problems? If yes circle all that apply: High Blood Pressure High Cholesterol Heart Infection A heart murmur Kawasaki Disease		
9. Has a doctor ever ordered a test for your heart? Example ECG/EKG/echocardiogram		
10. Do you get light headed or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
Heart Health Questions about your family	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50? (Incl. drowning, unexplained car accident, sudden infant death syndrome)		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan Syndrome, Arrhythmogenic Right Ventricular Cardiomyopathy, Long QT Syndrome, Short QT Syndrome, Brugada Syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, seizures, or near drowning?		
Bone and Joint Questions	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon, that caused you to miss a practice or game?		
18. Have you ever broken/fractured a bone or dislocated a joint?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace/case, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability?		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of Juvenile Arthritis or Connective Tissue Disease?		

Explain "Yes" answers here: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct

Signature of Athlete _____ Signature of Parent _____ Date _____

Barça Residency Academy Pre Participation Physical

Note: This form is to be filled out by the patient and parent prior to seeing the physician.

Medical Questions	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medication?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testical, your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headaches, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with the doctor?		
Females only	Yes	No
53. Have you ever had a menstrual period?		
54. How old were you when you had your first menstrual period?		
55. How many periods have you had in the last 12 months?		

Please Indicate if you have ever had any of the following:	Yes	No
Atlantoaxial Instability		
X-Ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged Spleen		
Hepatitis		
Osteopenia or osteoporosis		
Hepatitis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in the legs or arms		
Weakness in legs, feet, hands, or arms		
Recent change in coordination or ability to walk		
Spina bifida		
Latex Allergy		

Explain "Yes" answers here: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct		
Signature of Athlete _____	Signature of Parent _____	Date _____

Barça Residency Academy Pre Participation Physical Clearance Form



Name: _____ D.O.B: _____ Date of Exam: _____
Sex: M | F Age: _____

- ☐ Cleared for All Sports without restriction
- ☐ Cleared for All Sports without restriction with recommendations for further evaluation or treatment for: _____
- ☐ Not Cleared
 - ☐ Pending Further Evaluation
 - ☐ For Any Sports
 - ☐ For Certain Sports _____
Reason: _____

I have examined the above named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the institution at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardian)

Name of Physician (print/type) _____

Date: _____

Address: _____

Phone: _____

Signature of Physician: _____

Emergency Information

Allergies:

Other Information:

