FITEQ PRE-PARTICIPATION PHYSICAL FORM (PPE)

Athlete

Name | Gender as identified in passport

Date of Birth (DD/MM/YYYY)

Address

Street | City | Zip Code

Contact details

Mobile phone | Email

Parent/Guardian (if necessary)

Name | Relationship

Email | Mobile phone

Emergency Contact (may be member of Athlete entourage)

Name | Mobile phone

Email

Pre-Exercise Screening Questionnaire for COVID19

		Yes	No	Comments
1.	Do you feel a sore throat?			
2.	Do you feel cough and sputum production?			
3.	Do you feel fatigue?			
4.	Do you feel short of breath or difficulty breathing?			
5.	Do you feel fever? (more than 37.8°C)			
6.	Have you had fever for more than three days? (more than 37.8°C)			
7.	Have you had any contact with anyone who has been			

The decision regarding COVID19 clearance is at the discretion of the medical practicioner.
If you answered YES to 4 out of 7 questions, or question 6 and/or question 7, you should seek medical clearance and refrain from exercise until cleared.
If you answered NO to all question, you can be reasonably sure that you can exercise safely.

General Medical History *(please mark your answer with an "X")*

		Yes	No	Comments
1.	Have you had any medical problem or physical injury since your last physical exam?			
2.	Do you have asthma?			
3.	Do you have diabetes?			
4.	Do you have high blood pressure?			
5.	Do you have seizures?			
6.	Do you have sickle cell trait?			
7.	Have you have any other major medical problem?			
8.	Have you ever been hospitalized or had surgery?			
9.	Do you cough, wheeze, or have trouble breathing when exercising?			
10.	Do you use an inhaler?			
11.	Do you have a single organ (testicle or kidney)?			
12.	Are you currently taking any medicines or do you take any medicines on a regular basis (presciprtion or over the counter)?			
13.	Have you ever taken any supplements or vitamins to help with weight loss, weight gain, or to improve performance?			
14.	Do you have any allergies (seasonal, insects, food, or medicines)?			
15.	Have you ever had a rash or hives develop during or after exercise?			
16.	Do you have any skin problems other than acne?			
17.	Have you ever had a head injury, been knocked out, lost your memory, had your “bell rung”, or a concussion?			
18.	Have you ever had numbness or tingling in your arms, hands, legs, or feet?			
19.	Have you ever had a “stinger”, “burner”, or pinched nerve?			
20.	Have you ever become ill from exercising in the heat?			
21.	Have you had mononucleosis or any significant illness in the last 60 days?			
22.	Do you have trouble with your eyes/vision/wear glasses or contacts?			
23.	Do you have trouble with your hearing/wear hearing aids?			
24.	Do you want to weigh more or less than you do now?			
25.	Do you lose weight regularly to meet weight requirements for your sport or other reasons			
26.	Do you feel stressed out, overly tired, or depressed?			
27.	Are there any other issues you would like to discuss with the doctor?			

Cardiac history

		Yes	No	Comments
28.	Have you ever passed out during or after exercise?			
29.	Have you ever been dizzy during or after exercise?			
30.	Have you ever had chest pain or chest pressure during or after exercise?			
31.	Do you tire easily or more quickly than your friends during exercise?			
32.	Have you ever had racing of your heart or skipped heartbeats?			
33.	Have you ever been told you had a heart murmur?			
34.	Have you ever been told you had an enlarged heart?			
35.	Has any member of your family:			
	died of heart problems or sudden death before age 50?			
	been told they had a serious heart problem before age 50			
	been told they had marfan's syndrome			
36.	Has a physician ever denied or restricted your participation in sports?			

Ortopaedic history

37.	Have you ever broken or fractured any bones?			
38.	Have you ever dislocated or partially dislocated any joint?			
39.	Have you had any problems related to your:			
	- neck, spine, or back - shoulders – elbows -wrists, hands, or fingers - hips			
	– knees - ankles, feet, or toes - other			

Females only

40.	Are your periods regular (every month)?			
41.	Are your periods heavy?			
42.	When was your first period?	Month		Year
43.	When was your last period?	Month		Year

Additional comments

PHYSICAL EVALUATION

Name		Age		Date of birth	

Must Complete

General

Height		Weight	
Pulse	*Beats per Minute*	Respiration	

Vision	Left 20/	Right20/	
Corrected	Yes	No	*Please circle one*
If Yes	Glasses	Contacts	*Please circle one*

Special Attention / Others / Standard

	Normal	Abnormal	Comments
Musculoskeletal			
Hips (Hip Flexor)			
Neck			
Spine			
Lumbar (Lower back)			
Knees			
Ankles			
Elbows			
Wrists			
Hands			
Feet			
Cardiopulmonary			
Pulse			
Heart (ECG)			
Lungs			
Skin			
Abdominal (Ultrasound)			
Genitalia			

Clearance *(circle one)* **Cleared** **Conditional** **Not cleared**

Conditions in case of conditional clearance:

Other recommendations:

Physicians information

Name		Phone number	
Email		Place of practice	
Signature		Date	