



FIFA PRE-COMPETITION MEDICAL ASSESSMENT (PCMA)

COMPETITION LEVEL:

FIFA

CONFEDERATION

NATIONAL

PLAYER:

SURNAME: _____ FIRST NAME: _____

DATE OF BIRTH: _____ (DAY / MONTH / YEAR)

NATIONAL TEAM: _____

LOCAL CLUB: _____

COUNTRY OF CLUB: _____

1. COMPETITION HISTORY

Position on the field goalkeeper defender
 midfielder striker

Dominant leg left right both

Number of matches in the last 12 months _____

2. MEDICAL HISTORY

2.1 PRESENT AND PAST COMPLAINTS

General	no	yes, within the last 4 weeks		yes, prior to the last 4 weeks	
Flu-like symptoms	<input type="checkbox"/>	<input type="checkbox"/>			
Infections (esp. viral)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Heat illness	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Concussion	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Allergies to food, insects	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Allergies to drugs	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Heart and lung	no	within the last 4 weeks at rest.....during/after exercise		prior to last 4 weeks at rest...during/after exercise	
Chest pain or tightness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations / Arrhythmias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other heart problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Syncope	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	no	yes, within the last 4 weeks		yes, prior to the last 4 weeks	
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Abnormal lipid profile	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Seizures, epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Advised to give up sport	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
More quickly tired than team mates	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Diarrhoea illness	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	

Musculoskeletal system

Severe injury leading to more than four weeks of limited participation or absence from play/training:

<input type="checkbox"/> no	right -left		latest occurrence
	<input type="checkbox"/>	<input type="checkbox"/> groin strain	when? _____ (year)
	<input type="checkbox"/>	<input type="checkbox"/> strain of m. quadriceps femoris	when? _____ (year)
	<input type="checkbox"/>	<input type="checkbox"/> strain of hamstring	when? _____ (year)
	<input type="checkbox"/>	<input type="checkbox"/> ligament injury of the knee	when? _____ (year)
	<input type="checkbox"/>	<input type="checkbox"/> ligament injury of the ankle	when? _____ (year)
	<input type="checkbox"/>	<input type="checkbox"/> others, please specify: _____	when? _____ (year)

For others please provide diagnosis: _____

Operations of the musculoskeletal system:

<input type="checkbox"/> no	right -left		latest operation
	<input type="checkbox"/>	<input type="checkbox"/> hip joint	when? _____ (year)
	<input type="checkbox"/>	<input type="checkbox"/> groin (due to pubalgia)	when? _____ (year)
	<input type="checkbox"/>	<input type="checkbox"/> knee ligaments	when? _____ (year)
	<input type="checkbox"/>	<input type="checkbox"/> knee meniscus or cartilage	when? _____ (year)
	<input type="checkbox"/>	<input type="checkbox"/> Achilles tendon	when? _____ (year)
	<input type="checkbox"/>	<input type="checkbox"/> ankle joint	when? _____ (year)
	<input type="checkbox"/>	<input type="checkbox"/> other operations	when? _____ (year)

For others please provide diagnosis: _____

Current complaints, aches or pain:

no yes, please specify **body parts**

<input type="checkbox"/>	<input type="checkbox"/> head / face	<input type="checkbox"/> shoulder	right -left	
<input type="checkbox"/>	<input type="checkbox"/> cervical spine	<input type="checkbox"/> upper arm	<input type="checkbox"/>	<input type="checkbox"/> hip
<input type="checkbox"/>	<input type="checkbox"/> thoracic spine	<input type="checkbox"/> elbow	<input type="checkbox"/>	<input type="checkbox"/> groin
<input type="checkbox"/>	<input type="checkbox"/> lumbar spine	<input type="checkbox"/> forearm	<input type="checkbox"/>	<input type="checkbox"/> thigh
<input type="checkbox"/>	<input type="checkbox"/> sternum / ribs	<input type="checkbox"/> wrist	<input type="checkbox"/>	<input type="checkbox"/> knee
<input type="checkbox"/>	<input type="checkbox"/> abdomen	<input type="checkbox"/> hand	<input type="checkbox"/>	<input type="checkbox"/> lower leg
<input type="checkbox"/>	<input type="checkbox"/> pelvis / sacrum	<input type="checkbox"/> fingers	<input type="checkbox"/>	<input type="checkbox"/> Achilles tendon
			<input type="checkbox"/>	<input type="checkbox"/> ankle
			<input type="checkbox"/>	<input type="checkbox"/> foot, toe

Current diagnosis and treatment:

<input type="checkbox"/> no	right left		<input type="checkbox"/> rest	<input type="checkbox"/> physiotherapy	<input type="checkbox"/> surgery
	<input type="checkbox"/>	<input type="checkbox"/> pubalgia	<input type="checkbox"/> rest	<input type="checkbox"/> physiotherapy	<input type="checkbox"/> surgery
	<input type="checkbox"/>	<input type="checkbox"/> hamstring strain	<input type="checkbox"/> rest	<input type="checkbox"/> physiotherapy	<input type="checkbox"/> surgery
	<input type="checkbox"/>	<input type="checkbox"/> quadriceps strain	<input type="checkbox"/> rest	<input type="checkbox"/> physiotherapy	<input type="checkbox"/> surgery
	<input type="checkbox"/>	<input type="checkbox"/> knee sprain	<input type="checkbox"/> rest	<input type="checkbox"/> physiotherapy	<input type="checkbox"/> surgery
	<input type="checkbox"/>	<input type="checkbox"/> meniscus lesion	<input type="checkbox"/> rest	<input type="checkbox"/> physiotherapy	<input type="checkbox"/> surgery
	<input type="checkbox"/>	<input type="checkbox"/> tendinosis of Achilles tendon	<input type="checkbox"/> rest	<input type="checkbox"/> physiotherapy	<input type="checkbox"/> surgery
	<input type="checkbox"/>	<input type="checkbox"/> ankle sprain	<input type="checkbox"/> rest	<input type="checkbox"/> physiotherapy	<input type="checkbox"/> surgery
	<input type="checkbox"/>	<input type="checkbox"/> concussion	<input type="checkbox"/> rest	<input type="checkbox"/> physiotherapy	<input type="checkbox"/> surgery
	<input type="checkbox"/>	<input type="checkbox"/> low back pain	<input type="checkbox"/> rest	<input type="checkbox"/> physiotherapy	<input type="checkbox"/> surgery

2.2 FAMILY HISTORY (MALE RELATIVES < 55 YEARS, FEMALE RELATIVES < 65 YEARS)

	no	father	mother	sibling	other
Sudden cardiac death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudden infant death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent syncope	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart transplantation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker/Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marfan syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained drowning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained car accident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others (arthritis etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2.3 ROUTINE MEDICATION WITHIN LAST 12 MONTHS

	no	yes
Non-steroidal anti inflammatory drugs	<input type="checkbox"/>	<input type="checkbox"/>
Asthma medication	<input type="checkbox"/>	<input type="checkbox"/>
Antihypertensive drugs	<input type="checkbox"/>	<input type="checkbox"/>
Lipid lowering drugs	<input type="checkbox"/>	<input type="checkbox"/>
Antidiabetic drugs	<input type="checkbox"/>	<input type="checkbox"/>
Psychotropic drugs	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

3. GENERAL PHYSICAL EXAMINATION

Height _____ cm/_____ inch Weight: _____kg/_____ lbs

Thyroid gland normal abnormal
Lymph nodes/spleen normal abnormal

Lungs

Percussion normal abnormal

Breath sounds normal abnormal

Abdomen

Palpation normal abnormal

Marfan Criteria

no yes, please specify:
 chest deformities
 long arms and legs
 flat footedness
 scoliosis
 lens dislocation
 other: _____

4. CARDIOVASCULAR SYSTEM

- Rhythm normal arrhythmic
- Heart sounds normal abnormal, please specify:
 split
 paradoxically split
 3rd heart sound
 4th heart sound
- Heart murmurs no yes, please specify:
 systolic - intensity: ____/6
 diastolic - intensity: ____/6
 clicks
 changes during Valsalva manoeuvre
 changes when abruptly stands up
- Peripheral oedema no yes
- Jugular veins (45° position) normal abnormal
- Hepato-jugular reflux no yes

Blood vessels

- Peripheral pulses palpable not palpable
- Delay in femoral pulses no yes
- Vascular bruits no yes
- Varicose veins no yes

Heart rate after 5 Minutes rest

_____/min

Blood Pressure in Supine Position after 5 minutes rest

- Right arm ____ / ____ mmHg
- Left arm ____ / ____ mmHg
- Ankle ____ / ____ mmHg

4.1 12-LEAD RESTING ECG* IN SUPINE POSITION AFTER 5 MINUTES REST

* Please attach copy

Heart rate _____ /min

Rhythm/Conduction normal abnormal, please specify:
 premature ventricular beats
 premature supraventricular beats
 supraventricular tachycardia
 ventricular arrhythmia
 atrial flutter/fibrillation
 delta wave
 atrio-ventricular block, please specify:
 first degree
 second degree type I
 second degree type II
 third degree

Time indices PQ _____ ms
QRS _____ ms broader in V1, V2
QTc _____ ms

Atrial enlargement no yes, left (negative portion of the P wave in lead V1 ≥ 0.1 mV in depth and ≥ 0.04 s in duration)
 yes, right (peaked P wave in leads II and III or V1 ≥ 0.25 mV in amplitude)

Depolarisation / QRS complex

Axis normal abnormal ($\geq +120^\circ$ or -30° to -90°)

Voltage normal abnormal

LV hypertrophy no yes

Q Waves normal abnormal (>0.04 s in duration or $>25\%$ of height of ensuing R wave or QS pattern in two or more leads)

Bundle Branch Block no yes, please specify:
 complete (>0.12 s) left
 complete (>0.12 s) right
 incomplete left anterior
 incomplete left posterior
 incomplete right

R wave normal pathologic R or R' wave in lead V1 (≥ 0.5 mV in amplitude + R/S ratio ≥ 1)
 others

Repolarisation (ST-segment, T waves, QT-interval)

normal abnormal, please specify:

	<u>Lead</u>											
	I	II	III	aVR	aVL	AVF	V1	V2	V3	V4	V5	V6
ST-depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ST-elevation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T-wave flattening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T-wave inversion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Summarising assessment of ECG normal abnormal

4.2 ECHOCARDIOGRAPHY (normal values of general population)

* Please provide CD-rom/DVD with loops

Body surface area (BSA): _____ m²

Left ventricle (LV)

End-diastolic diameter _____ cm/m²
(normal values: ♀ 2.4-3.2 cm/m², ♂ 2.2-3.1cm/m²)

End-systolic diameter _____ cm/m²

End-diastolic interventricular septum thickness _____ cm/m²
(normal values: ♀ <0.9 cm/m², ♂ <1.0cm/m²)

Diastolic posterior wall thickness _____ cm/m²
(normal values: ♀ <0.9 cm/m², ♂ <1.0cm/m²)

LV Diastolic volume _____ ml/m²
(normal values: ♀, ♂ 35-75 ml/m²)

LV Systolic volume _____ ml/m²
(normal values: ♀, ♂ 12-30 ml/m²)

LVMMI (LV mass/BSA; linear method) _____ g/m²
(normal values: ♀ <95 g/m²), ♂ <115 g/m²)

Systolic function

Mitral anterior movement _____ mm

Fractional shortening (endocardial) _____ %
(normal values: ♀ >27 %, ♂ > 25 %)

Ejection fraction (Simpson biplane or area length method) _____ %
(normal value: ≥ 55%)

Regional wall motion normal abnormal

Diastolic function E Wave _____ cm/s
 A Wave _____ cm/s
 (E/A ratio) _____
 Deceleration time _____ ms
 E' (Tissue Doppler) septal _____ cm/s
 lateral wall _____ cm/s
 E/E' _____

Left atrium

Diameter (M-mode, parasternal long axis) _____ cm

Area (4-chamber view) _____ cm²
 (normal value: <20 cm²)

Volume (in Simpson or area length method) _____ ml/m²
 (normal values: ♀, ♂ < 28ml/m²)

Right atrium/Inferior Vena cava

Area (4-chamber view) _____ cm²
 (normal: <20 cm²)

IVC diameter _____ cm

Respiratory variability of the IVC >50% <50%

Right ventricle

Mid-RV diameter (4-chamber view, RVD 2) _____ cm (normal value: < 3.3 cm)

Base-to-apex length (4-chamber view, RVD 3) _____ cm (normal value: <7.9 cm)

Fac (fractional area change) _____ % (normal value: > 32%)

TAM (tricuspidal anterior motion) _____ mm

Systolic RV/RA gradient _____ mmHg

Regional wall motion normal abnormal

Local aneurysm no yes

Hypertrophy no yes

Free wall thickness _____ cm (normal: < 0.5 cm)

Cardiac valves

Aortic valve

normal

abnormal

Mitral valve

normal

abnormal

Tricuspid valve

normal

abnormal

Pulmonal valve

normal

abnormal

Specify abnormalities: _____

Aortic root diameter (AoD, Sinus Valsalva) _____ cm

Aorta ascendens _____ cm

Summarising assessment of echocardiography normal abnormal

5. BLOOD RESULTS (FASTING)

Haemoglobin _____ mg/dL

Haematocrit _____ %

Erythrocytes _____ mg/dL

Thrombocytes _____ mg/dL

Leukocytes _____ mg/dL

Sodium _____ mmol/L

Potassium _____ mmol/L

Creatinine _____ μ mol/l

Cholesterol (total) _____ mmol/L

LDL Cholesterol _____ mmol/L

HDL Cholesterol _____ mmol/L

Triglycerides _____ mmol/l

Glucose _____ mmol/l

C-reactive Protein _____ mg/l

6. MUSCULOSKELETAL SYSTEM

6.1 SPINAL COLUMN AND PELVIC LEVEL

Spine form	<input type="checkbox"/> normal	<input type="checkbox"/> flat		
		<input type="checkbox"/> hyperkyphosis		
		<input type="checkbox"/> hyperlordosis		
		<input type="checkbox"/> scoliosis		
Pelvic level	<input type="checkbox"/> even	_____cm lower	<input type="checkbox"/> right	<input type="checkbox"/> left
Sacroiliac joint	<input type="checkbox"/> normal	<input type="checkbox"/> abnormal		
Cervical rotation				
right	_____°	painful	<input type="checkbox"/> no	<input type="checkbox"/> yes
left	_____°	painful	<input type="checkbox"/> no	<input type="checkbox"/> yes
Spinal flexion				
Distance fingertips to floor		_____cm		

6.2 EXAMINATION OF HIP, GROIN AND THIGH

Flexibility of the hip

Flexion (passive)

right	<input type="checkbox"/> normal	<input type="checkbox"/> limited _____°	painful	<input type="checkbox"/> no	<input type="checkbox"/> yes
left	<input type="checkbox"/> normal	<input type="checkbox"/> limited _____°	painful	<input type="checkbox"/> no	<input type="checkbox"/> yes

Extension (passive)

right	<input type="checkbox"/> normal	<input type="checkbox"/> limited _____°	painful	<input type="checkbox"/> no	<input type="checkbox"/> yes
left	<input type="checkbox"/> normal	<input type="checkbox"/> limited _____°	painful	<input type="checkbox"/> no	<input type="checkbox"/> yes

Inward rotation (in 90° flexion)

right	_____°	painful	<input type="checkbox"/> no	<input type="checkbox"/> yes
left	_____°	painful	<input type="checkbox"/> no	<input type="checkbox"/> yes

Outward rotation (in 90° flexion)

right	_____°	painful	<input type="checkbox"/> no	<input type="checkbox"/> yes
left	_____°	painful	<input type="checkbox"/> no	<input type="checkbox"/> yes

Abduction

right	_____°	painful	<input type="checkbox"/> no	<input type="checkbox"/> yes
left	_____°	painful	<input type="checkbox"/> no	<input type="checkbox"/> yes

Tenderness on groin palpation

right	<input type="checkbox"/> no	<input type="checkbox"/> pubis	<input type="checkbox"/> inguinal canal
left	<input type="checkbox"/> no	<input type="checkbox"/> pubis	<input type="checkbox"/> inguinal canal

Hernia

right no yes, please specify _____
left no yes, please specify _____

Muscles

Adductors

right normal shortened painful: no yes
left normal shortened painful: no yes

Hamstrings

right normal shortened painful: no yes
left normal shortened painful: no yes

Iliopsoas

right normal shortened painful: no yes
left normal shortened painful: no yes

Rectus femoris

right normal shortened painful: no yes
left normal shortened painful: no yes

Tensor fascia latae muscle (iliotibial band)

right normal shortened painful: no yes
left normal shortened painful: no yes

6.3 EXAMINATION OF KNEE

Knee joint axis

right normal genu varum genu valgum
left normal genu varum genu valgum

Flexion (passive)

right normal limited _____° painful no yes
left normal limited _____° painful no yes

Extension (passive)

right 0° limited _____° painful no yes
 hyper-extension _____°
left 0° limited _____° painful no yes
 hyper-extension _____°

Lachman test

right normal + ++ +++
left normal + ++ +++

Anterior drawer sign (knee joint in 90° flexion)

right normal + ++ +++
left normal + ++ +++

Posterior drawer sign (knee joint in 90° flexion)

right	<input type="checkbox"/> normal	<input type="checkbox"/> +	<input type="checkbox"/> ++	<input type="checkbox"/> +++
left	<input type="checkbox"/> normal	<input type="checkbox"/> +	<input type="checkbox"/> ++	<input type="checkbox"/> +++

Valgus stress, in extension

right	<input type="checkbox"/> normal	<input type="checkbox"/> +	<input type="checkbox"/> ++	<input type="checkbox"/> +++
left	<input type="checkbox"/> normal	<input type="checkbox"/> +	<input type="checkbox"/> ++	<input type="checkbox"/> +++

Valgus stress, in 30° flexion

right	<input type="checkbox"/> normal	<input type="checkbox"/> +	<input type="checkbox"/> ++	<input type="checkbox"/> +++
left	<input type="checkbox"/> normal	<input type="checkbox"/> +	<input type="checkbox"/> ++	<input type="checkbox"/> +++

Varus stress, in extension

right	<input type="checkbox"/> normal	<input type="checkbox"/> +	<input type="checkbox"/> ++	<input type="checkbox"/> +++
left	<input type="checkbox"/> normal	<input type="checkbox"/> +	<input type="checkbox"/> ++	<input type="checkbox"/> +++

Varus stress, in 30° flexion

right	<input type="checkbox"/> normal	<input type="checkbox"/> +	<input type="checkbox"/> ++	<input type="checkbox"/> +++
left	<input type="checkbox"/> normal	<input type="checkbox"/> +	<input type="checkbox"/> ++	<input type="checkbox"/> +++

6.4 EXAMINATION OF LOWER LEG, ANKLE AND FOOT**Tenderness of Achilles tendon**

right	<input type="checkbox"/> no	<input type="checkbox"/> yes
left	<input type="checkbox"/> no	<input type="checkbox"/> yes

Anterior drawer sign

right	<input type="checkbox"/> normal	<input type="checkbox"/> +	<input type="checkbox"/> ++	<input type="checkbox"/> +++
left	<input type="checkbox"/> normal	<input type="checkbox"/> +	<input type="checkbox"/> ++	<input type="checkbox"/> +++

Dorsi flexion

right	_____°	painful	<input type="checkbox"/> no	<input type="checkbox"/> yes
left	_____°	painful	<input type="checkbox"/> no	<input type="checkbox"/> yes

Plantar flexion

right	_____°	painful	<input type="checkbox"/> no	<input type="checkbox"/> yes
left	_____°	painful	<input type="checkbox"/> no	<input type="checkbox"/> yes

Total supination

right	<input type="checkbox"/> normal	<input type="checkbox"/> decreased	<input type="checkbox"/> increased
left	<input type="checkbox"/> normal	<input type="checkbox"/> decreased	<input type="checkbox"/> increased

Total pronation

right	<input type="checkbox"/> normal	<input type="checkbox"/> decreased	<input type="checkbox"/> increased
left	<input type="checkbox"/> normal	<input type="checkbox"/> decreased	<input type="checkbox"/> increased

Metatarsophalangeal joint

right	<input type="checkbox"/> normal	<input type="checkbox"/> pathological
left	<input type="checkbox"/> normal	<input type="checkbox"/> pathological

7. SUMMARISING ASSESSMENT

Medical history

- Normal
- Eligible for football, follow-up required,
please specify: _____
- Play not recommended
please specify: _____

Clinical examination

- Normal
- Eligible for football, follow-up required,
please specify: _____
- Play not recommended
please specify: _____

Orthopaedic examination

- Normal
- Eligible for football, follow-up required,
please specify: _____
- Play not recommended
please specify: _____

12-lead resting ECG

- Normal
- Eligible for football, follow-up required,
please specify: _____
- Play not recommended
please specify: _____

Echocardiography

- Normal
- Eligible for football, follow-up required,
please specify: _____
- Play not recommended
please specify: _____

Other findings

- Normal
- Eligible for football, follow-up required,
please specify: _____
- Play not recommended
please specify: _____

ELIGIBILITY FOR COMPETITIVE FOOTBALL

yes **no**

8. EXAMINING PHYSICIAN AND INSTITUTION

Name of the examining physician: _____

Address: _____

Phone No.: _____ Fax No: _____

Email _____

Date: _____ Signature: _____