



FIFA PRE-COMPETITION MEDICAL ASSESSMENT (PCMA)

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"/> head / face <input type="checkbox"/> cervical spine <input type="checkbox"/> thoracic spine <input type="checkbox"/> lumbar spine <input type="checkbox"/> sternum / ribs <input type="checkbox"/> abdomen <input type="checkbox"/> pelvis / sacrum	<input type="checkbox"/> shoulder <input type="checkbox"/> upper arm <input type="checkbox"/> elbow <input type="checkbox"/> forearm <input type="checkbox"/> wrist <input type="checkbox"/> hand <input type="checkbox"/> fingers	<table border="0"> <tr><td colspan="2" style="text-align: center;">right -left</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/> hip</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/> groin</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/> thigh</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/> knee</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/> lower leg</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/> Achilles tendon</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/> ankle</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/> foot, toe</td></tr> </table>	right -left		<input type="checkbox"/>	<input type="checkbox"/> hip	<input type="checkbox"/>	<input type="checkbox"/> groin	<input type="checkbox"/>	<input type="checkbox"/> thigh	<input type="checkbox"/>	<input type="checkbox"/> knee	<input type="checkbox"/>	<input type="checkbox"/> lower leg	<input type="checkbox"/>	<input type="checkbox"/> Achilles tendon	<input type="checkbox"/>	<input type="checkbox"/> ankle	<input type="checkbox"/>	<input type="checkbox"/> foot, toe
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<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"/>	<input type="checkbox"/> hamstring strain			
	<input type="checkbox"/>	<input type="checkbox"/> quadriceps strain			
	<input type="checkbox"/>	<input type="checkbox"/> knee sprain			
	<input type="checkbox"/>	<input type="checkbox"/> meniscus lesion			
	<input type="checkbox"/>	<input type="checkbox"/> tendinosis of Achilles tendon			
	<input type="checkbox"/>	<input type="checkbox"/> ankle sprain			
	<input type="checkbox"/>	<input type="checkbox"/> concussion			
	<input type="checkbox"/>	<input type="checkbox"/> low back pain			

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
(normal values: ♀ <3.2 cm/m², ♂ <3.1cm/m²)

End-systolic diameter _____ cm

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

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

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

LV Systolic volume _____ ml
(normal values: ♀, ♂ <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

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 normal + ++ +++
left normal + ++ +++

Valgus stress, in extension

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

Valgus stress, in 30° flexion

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

Varus stress, in extension

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

Varus stress, in 30° flexion

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

6.4 EXAMINATION OF LOWER LEG, ANKLE AND FOOT

Tenderness of Achilles tendon

right no yes
left no yes

Anterior drawer sign

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

Dorsi flexion

right _____° painful no yes
left _____° painful no yes

Plantar flexion

right _____° painful no yes
left _____° painful no yes

Total supination

right normal decreased increased
left normal decreased increased

Total pronation

right normal decreased increased
left normal decreased increased

Metatarsophalangeal joint

right
left

normal
 normal

pathological
 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: _____