



Pre-competition Medical Assessment (PCMA) التقييم الطبي قبل المنافسات

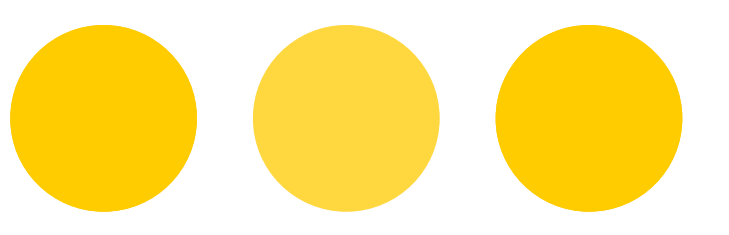
Full Name: _____

Date of birth: _____ (Day / Month / Year)

_____ الاسم الثلاثي:

_____ تاريخ الميلاد : (هجري)





1. Competition History

Dominant hand

left

right

both

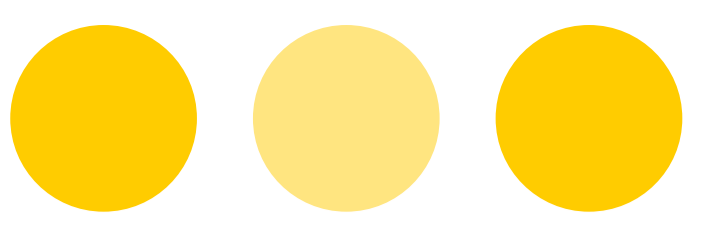
Competitions in the last 12 months _____

2. Medical History

2.1 Present and Past Complaints

Heart and lung	NO	within the last 4 weeks at rest during/after exercise	prior the last 4 weeks at rest during/after exercise
Chest pain or tightness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ashtma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other heart problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Syncope	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	NO	Yes, within the last 4 weeks	Yes, prior 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 | yes, | <input type="checkbox"/> groin strain | when?_____ (year) |
| | | <input type="checkbox"/> strain of m. quadriceps femoris | when?_____ (year) |
| | | <input type="checkbox"/> strain of hamstring | when?_____ (year) |
| | | <input type="checkbox"/> ligament injury of the knee | when?_____ (year) |
| | | <input type="checkbox"/> ligament injury of the ankle | when?_____ (year) |
| | | <input type="checkbox"/> others, please specify:_____ | when?_____ (year) |

For others please provide diagnosis:_____

Operations of the musculoskeletal system:

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

For others please provide diagnosis:_____

Current complaints, aches or pain:

no yes, please specify body parts

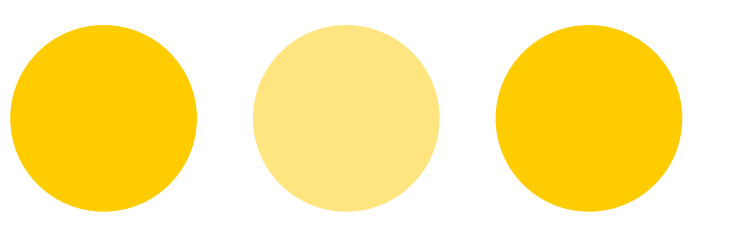
- head / face
- cervical spine
- thoracic spine
- lumbar spine
- sternum / ribs
- abdomen
- pelvis / sacrum

- shoulder
- upper arm
- elbow
- forearm
- wrist
- hand
- fingers

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 |





2.2 Routine medication within last 12 month

	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 BMI: _____

Arm Span: _____ cm/_____ inch Ape Index: _____

ENT normal abnormal

If abnormal results:

Ophthalmologist normal abnormal

if abnormal results :

Extremities normal abnormal

if abnormal results :

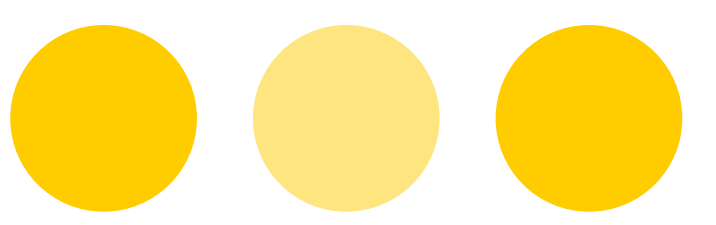
Hearing normal abnormal

if abnormal results :

Pregnancy Yes No

if yes details :





Players And Examining Physician Declaration For Pcma

1. Player

Name: _____

I hereby confirm that I have undergone the Pre-competition medical assessment (PCMA)

Date: _____ Signature: _____

2. Examining Physician and Institution

Name of the examining physician: _____

Address: _____

Phone No.: _____

Email _____

I hereby confirm that the above-mentioned player has undergone a pre-medical competition assessment (PCMA).

I hereby confirm of my evaluation:

ELIGIBILITY FOR ROCK CLIMBING

YES NO

Date: _____ Signature: _____

Stamp: