CAF PRE-COMPETITION CARDIAC ASSESSMENT + (PCCA +)

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**

<table>
<thead>
<tr>
<th>General</th>
<th>no</th>
<th>yes, within the last 4 weeks</th>
<th>yes, prior to the last 4 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flu-like symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infections (esp. viral)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatic fever</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heat illness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concussion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies to food, insects</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies to drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Heart and lung</strong></td>
<td>no</td>
<td>within the last 4 weeks at rest during/after exercise</td>
<td>prior to last 4 weeks at rest during/after exercise</td>
</tr>
<tr>
<td>Chest pain or tightness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shortness of breath</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palpitations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syncope</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abnormal lipid profile</td>
<td>no</td>
<td>yes, within the last 4 weeks</td>
<td>yes, prior to the last 4 weeks</td>
</tr>
<tr>
<td>Seizures, epilepsy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advised to give up sport</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More quickly tired than team mates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhoea illness</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional notes: ____________________________________________________
### Additional Specific COVID-19 Personal History and Symptoms

Have you been tested positive to Coronavirus (Covid-19) before? (PCR only)  
- Yes ☐  
- No ☐

If yes, have you ever had a Chest CT Scan with appearance of COVID-19 pneumonia characterized by ground-glass opacities? (Please specify the date)  
- Yes ☐  
- No ☐

Date ______________________

If yes, have you ever had some of the following signs and symptoms?  
- Fever within the past four (04) days  
- Dry cough  
- Tiredness  
- Aches and pains  
- Muscular weakness  
- Sore throat  
- Vomiting or Diarrhea  
- Loss of taste or smell  
- Difficulty breathing or shortness of breath

### 2.2 Family History (Male relatives < 55 years, Female relatives < 65 years)

<table>
<thead>
<tr>
<th>Condition</th>
<th>No</th>
<th>Father</th>
<th>Mother</th>
<th>Sibling</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudden cardiac death</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Sudden infant death</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hypertension</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Recurrent syncope</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Heart transplantation</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Heart surgery</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Pacemaker/Defibrillator</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Marfan syndrome</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Unexplained drowning</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Unexplained car accident</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Stroke</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Diabetes</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Cancer</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Others (arthritis etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

### 2.3 Routine Medication within Last 12 Months

<table>
<thead>
<tr>
<th>Medication</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-steroidal anti inflammatory drugs</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Asthma medication</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Antihypertensive drugs</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Lipid lowering drugs</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Antidiabetic drugs</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Psychotropic drugs</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
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**

Palpatation   □ 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

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

*PLEASE RECORD AND STORE ECG FOR CLINICAL AND LEGAL ISSUES.

PLEASE PERFORM AND ASSESS THE 12-LEAD ECG ACCORDING TO THE CURRENT INTERNATIONAL (SEATTLE) CRITERIA². CONSULT A CARDIOLOGIST IN CASE OF ANY DOUBT.

REQUIRED PARAMETERS ARE MISSING OR INCORRECT.

**Summary assessment of ECG**  ☐ normal  ☐ abnormal, please specify:
4.2 If 12-LEAD RESTING ECG ABNORMAL, HEART ULTRASOUND

* Please record and store Echo loops for clinical and legal issues.

The echocardiography should be performed by a designated physician and expert in echocardiography with particular experience in the assessment of athletes. The examination should be based on the internationally accepted echo guidelines in “non-athletes”. However, as athletes may exhibit physiologic deviations from conventional “ranges of normal”, we also refer to corresponding specific sports cardiology literature.

Parasternal long axis:
PARASTERNAL SHORT AXIS (INCL. CORONARY ARTERY ORIGIN):
APICAL VIEWS:

LEFT VENTRICLE:
- DIMENSIONS: NORMAL □ ABNORMAL □
LVEDV: _____ ML

LVEDVI: _____ ML

- Systolic Function: Normal [ ] Abnormal [ ]
  LVEF: _____ %

- Diastolic Function: Normal [ ] Abnormal [ ]

Right Ventricle:
- Dimensions: Normal [ ] Abnormal [ ]
- Function: Normal [ ] Abnormal [ ]

Left Atrium:
- Dimensions: Normal [ ] Abnormal [ ]
- LAVI: _____ ML/M²

Right Atrium:
- Dimensions: Normal [ ] Abnormal [ ]
- RAVI: _____ ML/M²

Apical 2-Chamber View:
Normal [ ] Abnormal [ ]

Apical 3-Chamber View:
Normal [ ] Abnormal [ ]

Subcostal View:
Normal [ ] Abnormal [ ]

Jugular View:
Dimensions of the Aortic Arc: Normal [ ] Abnormal [ ]
Aortic Isthmus Stenosis: Yes [ ] No [ ]

Summary:
Structural Heart Disease (Including Relevant Valve or Myocardial Disease, Coronary Anomaly):
No [ ] Yes [ ] (Please Specify: ___________________________)

Normal Dimensions:
Yes [ ] No [ ] (Specify: ___________________________)

Normal Function:
Yes [ ] No [ ] (Specify: ___________________________)

Pulmonary Hypertension:
No [ ] Yes [ ] (Highest Systolic RV-/RA-Gradient _____ mmHg)

Further Assessment Required:
No [ ] Yes [ ] (Please Specify: ___________________________)
<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haemoglobin Rate (if possible type)</td>
<td>______ mg/dL (  )</td>
</tr>
<tr>
<td>Haematocrit</td>
<td>______ %</td>
</tr>
<tr>
<td>Erythrocytes</td>
<td>______ mg/dL</td>
</tr>
<tr>
<td>Thrombocytes</td>
<td>______ mg/dL</td>
</tr>
<tr>
<td>Leukocytes</td>
<td>______ mg/dL</td>
</tr>
<tr>
<td>Sodium</td>
<td>______ mmol/L</td>
</tr>
<tr>
<td>Potassium</td>
<td>______ mmol/L</td>
</tr>
<tr>
<td>Creatinine</td>
<td>______ µmol/L</td>
</tr>
<tr>
<td>Cholesterol (total)</td>
<td>______ mmol/L</td>
</tr>
<tr>
<td>LDL Cholesterol</td>
<td>______ mmol/L</td>
</tr>
<tr>
<td>HDL Cholesterol</td>
<td>______ mmol/L</td>
</tr>
<tr>
<td>Triglycerides</td>
<td>______ mmol/L</td>
</tr>
<tr>
<td>Glucose</td>
<td>______ mmol/L</td>
</tr>
<tr>
<td>C - reactive protein</td>
<td>______ mg/L</td>
</tr>
</tbody>
</table>
If abnormalities arise in any of the examination results relating to the PCMA, we strongly recommend consultation with the respective medical expert. Please also refer to the Associations’ Declaration of Agreement to the Pre-Competition Medical Assessment (PCMA). The signed declaration must be returned to the FIFA Medical & Anti-Doping Department before the competition.

6. COVID-19 SPECIFIC TESTS

- In the event of recovery after contamination and known and recognized clinical form of COVID-19: Completely redo the PCMA examination
  - Pulmonary computed tomography (scanner): Search for specific COVID-19 images
  - Cardiac MRI: Look for signs of myocarditis

- Biology: PCR tests MD-14
  - Molecular tests by RT-PCR for the detection of the SARS-CoV-2 coronavirus genome
  - “Virologic Testings” which detect the presence of the SARS-CoV-2 viral genome in the body. NB. Please attach any Imaging and/or Laboratory reports

7. Players' Physical Fitness Certificate (Optional)

- Issued by the Technical Staff of the Team

- Participate in the injury prevention program
  - Iso-kinetic test (Cybex, Contrex or Biodex type)
  - Stress Test (VO2Max)
  - Test - Dental Profile (Occlusion - Odontology)
  - Field tests
8. **SUMMARISING ASSESSMENT**

**Suspected heart disease**

☐ no  ☐ yes, please specify: ______________________________________

**Other diseases**

☐ no  ☐ yes, please specify: ______________________________________

**ELIGIBILITY FOR COMPETITIVE FOOTBALL**

☐ yes  ☐ no

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**8. EXAMINING PHYSICIAN AND INSTITUTION**

Name of the examining physician:

Address:

Phone No.: 

Fax No: 

Email 

Date: 

Signature: