UNITED STATES YOUTH SOCCER

Proud Member of the United States Soccer Federation, Inc.

OLYMPIC DEVELOPMENT PROGRAM

MEDICAL HISTORY QUESTIONNAIRE

NAME _____
LAST FIRST MIDDLE

ADDRESS _____
STREET CITY STATE ZIP

DATE OF BIRTH _____ SEX ___ EMERGENCY CONTACT _____ PHONE (____) _____

PLEASE CIRCLE "YES" OR "NO" AND PROVIDE ADDITIONAL DETAILS WHERE REQUESTED ON BOTH SIDES OF THIS FORM. ALL INFORMATION WILL BE CONFIDENTIAL.

1. Do you have allergies to medicines, pollen, foods, and/or stinging insects? NO YES
   (Please List)

2. Do you take any prescribed medication on a permanent or semi-permanent basis (steroids, birth control pills, anti-inflammatories, antibiotics, etc.)? NO YES
   (List & give reason)

3. Have you ever had a seizure? NO YES

4. Have you ever been told by a doctor that you have epilepsy? NO YES
   (List medication)

5. Have you ever been treated for diabetes? NO YES

6. Have you ever been told by a doctor that you were anemic? NO YES
   When?

7. Have you ever been told by a doctor that you have sickle cell anemia or that you carry the sickle cell trait? NO YES

8. Do you have or have you ever had high blood pressure? NO YES
   (List medication)

9. Do you have or have you ever had the following diseases?
   - Heart disease (heart murmur, rheumatic fever) Give date _____ NO YES
   - Lung disease (pneumonia) Give date _____ NO YES
   - Kidney disease (infections) Give date _____ NO YES
   - Liver disease (mononucleosis, hepatitis) Give date _____ NO YES

10. Do you or have you ever been told by a doctor that you have asthma? NO YES
    (List medications)

11. Do you or have you ever had a hernia or "rupture"? NO YES
    Has it been repaired? NO YES

12. Have you ever been hospitalized? Please give dates and reason. NO YES

13. Have you been "knocked out" (unconscious)? (If yes, List Dates) NO YES

14. Have you had a concussion or other head injury? (If yes, List Dates) NO YES

15. Have you ever had a neck injury involving bones, nerves or discs that disabled you for a week or longer? Type of injury? NO YES
    Dates

16. Do you wear glasses or contacts during competition? NO YES

17. Do you wear any of the following dental appliances: PERMANENT BRIDGE, BRACES, REMOVABLE RETAINER, PERMANENT RETAINER, REMOVABLE PARTIAL PLATE, FULL PLATE, PERMANENT CROWN OR JACKET? NO YES (circle those which apply)

18. Have you had a broken bone or dislocation in the past 2 years? NO YES
R or L _____ What bone? _____ Dates

19. Have you had a shoulder injury (dislocation, separation, etc.) NO YES
R or L _____ Type of injury?_____Treatment? _____
Dates

20. Have you ever injured your back? NO YES
Type of injury? _____ Treatment? _____ Date

21. Do you have back pain? NO YES (circle those which apply)
SELDOM, OCCASIONALLY, FREQUENTLY, WITH VIGOROUS EXERCISE, WITH HEAVY LIFTING

22. Have you injured your knee? Type of injury? _____ NO YES
R or L _____ Treatment? _____ Date

23. Have you ever injured your ankle? Type of injury? _____ NO YES
R or L _____ Treatment? _____ Date

24. Do you have a pin, screw, or plate in your body? NO YES
Where in your body? _____ Date

25. Have you ever had a menstrual period? NO YES
If yes, age when you had your first menstrual period _____
How many periods have you had in the last 12 months? _____

26. Do you have any other conditions that we should be aware of? NO YES
(specify & give details)

27. Please give the date of your last immunization for: tetanus _____ polio _____
mumps _____ rubella _____ measles _____ chicken pox _____

THE QUESTIONS ON THIS FORM HAVE BEEN ANSWERED COMPLETELY AND TRUTHFULLY TO THE BEST OF MY KNOWLEDGE.

_____ _____ _____ _____
Signature of Parent/Guardian Date Signature of Player Date