



**OLYMPIC DEVELOPMENT PROGRAM  
MEDICAL HISTORY QUESTIONNAIRE**

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SEX \_\_\_\_M \_\_\_\_F

EMERGENCY CONTACT \_\_\_\_\_ HM PH (\_\_\_\_) \_\_\_\_\_ WK PH (\_\_\_\_) \_\_\_\_\_

PLEASE CIRCLE EITHER "YES" OR "NO" TO ALL QUESTIONS AND PROVIDE ADDITIONAL DETAILS WHERE REQUESTED. YOU MAY PUT DETAILS ON THE BACK OF THIS FORM IF NEEDED. ALL INFORMATION IS CONFIDENTIAL.

- 1) ARE YOU ALLERGIC TO ANY MEDICATION (ASPIRIN, PENICILLIN, SULFA, ETC)? **YES NO** (LIST) \_\_\_\_\_
- 2) DO YOU TAKE ANY PRESCRIBED MEDICATION ON A PERMANENT BASIS OR SEMI-PERMANENT BASIS (STEROIDS, BIRTH CONTROL PILLS, ANTI-INFLAMMATORIES, ANTIBIOTICS, ETC)? **YES NO** (LIST & GIVE REASON) \_\_\_\_\_
- 3) HAVE YOU EVER HAD ANY EPILEPTIC SEIZURE? **YES NO**
- 4) HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE EPILEPSY? **YES NO** (LIST MEDICATION) \_\_\_\_\_
- 5) HAVE YOU EVER BEEN TREATED FOR DIABETES? **YES NO**
- 6) HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU WERE ANEMIC? **YES NO** WHEN? \_\_\_\_\_
- 7) HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE SICKLE CELL ANEMIA? **YES NO**
- 8) HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE SICKLE CELL TRAIT? **YES NO** \_\_\_\_\_
- 9) DO YOU HAVE OR HAVE YOU EVER HAD HIGH BLOOD PRESSURE? **YES NO** (LIST MEDICATION) \_\_\_\_\_
- 10) DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING DISEASES?  
 HEART DISEASE (HEART MURMUR, RHEUMATIC FEVER) **YES NO** (GIVE DATE) \_\_\_\_\_  
 LUNG DISEASE (PNEUMONIA) **YES NO** (GIVE DATE) \_\_\_\_\_  
 KIDNEY DISEASE (INFECTIOUS) **YES NO** (GIVE DATE) \_\_\_\_\_  
 LIVER DISEASE (MONONUCLEOSIS, HEPATITIS) **YES NO** (GIVE DATE) \_\_\_\_\_
- 11) DO YOU HAVE OR HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE ASTHMA? **YES NO** (LIST MEDICATION) \_\_\_\_\_
- 12) DO YOU HAVE OR HAVE YOU EVER HAD A HERNIA OR "RUPTURE"? **YES NO** HAS IT BEEN REPAIRED? \_\_\_\_\_ DATE \_\_\_\_\_
- 13) HAVE YOU EVER BEEN "KNOCKED OUT"(UNCONSCIOUS) IN THE PAST 3 YEARS? **YES NO** (LIST DATES) \_\_\_\_\_
- 14) HAVE YOU EVER HAD A CONCUSSION OR OTHER HEAD INJURY IN THE PAST 3 YEARS? **YES NO** (LIST DATES) \_\_\_\_\_
- 15) HAVE YOU STAYED OVERNIGHT IN THE HOSPITAL DUE TO A HEAD INJURY? **YES NO** (LIST DATES) \_\_\_\_\_
- 16) HAVE YOU EVER HAD A NECK INJURY INVOLVING BONES, NERVES, OR DISKS THAT DISABLED YOU FOR A WEEK OR LONGER?  
**YES NO** TYPE OF INJURY \_\_\_\_\_ DATES \_\_\_\_\_
- 17) DO YOU WEAR GLASSES OR CONTACTS DURING COMPETITION? **YES NO**
- 18) DO YOU WEAR ANY OF THE FOLLOWING DENTAL APPLIANCES? **YES NO** (CIRCLE THOSE WHICH APPLY) PERMANENT BRIDGE, BRACES, REMOVABLE RETAINER, PERMANENT RETAINER, REMOVABLE PARTIAL PLATE, FULL PLATE, PERMANENT CROWN OR JACKET?
- 19) HAVE YOU HAD A BROKEN BONE OR FRACTURE IN THE PAST 2 YEARS? **YES NO** \_\_\_\_RIGHT OR \_\_\_\_LEFT  
 WHAT BONE(S) \_\_\_\_\_ DATES \_\_\_\_\_
- 20) HAVE YOU EVER HAD A SHOULDER INJURY IN THE PAST 2 YEARS THAT DISABLED YOU FOR A WEEK OR LONGER? (DISLOCATION, SEPARATION, ETC) **YES NO** \_\_\_\_RIGHT OR \_\_\_\_LEFT TYPE OF INJURY \_\_\_\_\_ DATE \_\_\_\_\_
- 21) HAVE YOU EVER HAD SHOULDER SURGERY? **YES NO** \_\_\_\_RIGHT OR \_\_\_\_LEFT DATE \_\_\_\_\_  
 WHAT WAS DONE AND WHY? \_\_\_\_\_
- 22) HAVE YOU EVER INJURED YOUR BACK? **YES NO** TYPE OF INJURY \_\_\_\_\_ DATE \_\_\_\_\_
- 23) DO YOU HAVE BACK PAIN? **YES NO** (CIRCLE THOSE THAT APPLY) SELDOM, OCCASIONALLY, FREQUENTLY, WITH VIGOROUS EXERCISE, WITH HEAVY LIFTING
- 24) HAVE YOU INJURED YOUR KNEE IN THE PAST 2 YEARS? **YES NO** \_\_\_\_RIGHT OR \_\_\_\_LEFT DATE \_\_\_\_\_
- 25) HAVE YOU BEEN TOLD BY A DOCTOR OR ATHLETIC TRAINER THAT YOU INJURED THE CARTILAGE IN YOUR KNEE? **YES NO**  
 \_\_\_\_RIGHT OR \_\_\_\_LEFT DATE \_\_\_\_\_
- 26) HAVE YOU BEEN TOLD BY A DOCTOR OR ATHLETIC TRAINER THAT YOU INJURED THE LIGAMENTS IN YOUR KNEE? **YES NO**  
 \_\_\_\_RIGHT OR \_\_\_\_LEFT DATE \_\_\_\_\_
- 27) HAVE YOU HAD KNEE SURGERY? **YES NO** \_\_\_\_RIGHT OR \_\_\_\_LEFT WHAT WAS DONE? \_\_\_\_\_ DATE \_\_\_\_\_
- 28) HAVE YOU HAD A SEVERE ANKLE SPRAIN IN THE PAST 2 YEARS? **YES NO** \_\_\_\_RIGHT OR \_\_\_\_LEFT DATE \_\_\_\_\_
- 29) DO YOU HAVE A PIN, SCREW, OR PLATE IN YOUR BODY? **YES NO** LOCATED WHERE \_\_\_\_\_ DATE \_\_\_\_\_
- 30) DO YOU HAVE OTHER CONDITIONS THAT WE SHOULD BE AWARE OF (I.E. ULCERS, PREGNANCY, FOOD OR INSECT ALLERGIES, TENDINITIS, ETC)? **YES NO** (SPECIFY & GIVE DETAILS) \_\_\_\_\_
- 31) DATE OF LAST IMMUNIZATION: \_\_\_\_TETANUS \_\_\_\_POLIO \_\_\_\_MUMPS \_\_\_\_RUBELLA \_\_\_\_MEASLES

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

**PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**ATHLETE'S SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_