

MEDICAL HISTORY QUESTIONNAIRE –US YOUTH SOCCER REGION IV ODP

LAST NAME _____ FIRST NAME _____ MIDDLE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ - _____ - _____ GENDER: M ___ F ___

EMERGENCY CONTACT _____ HM PH (____) _____ CELL PH (____) _____

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

1. Are you allergic to any medication (aspirin, penicillin, sulfa, etc)? **NO YES** (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 and give reason) _____
3. Have you ever had an epileptic 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 have sickle cell anemia? **NO YES**
8. Do you or have you ever had high blood pressure? **NO YES** (List medication) _____
9. Do you or have you ever had the following diseases?
NO YES (give date) _____ heart disease (heart murmur, rheumatic fever)
NO YES (give date) _____ lung disease (pneumonia)
NO YES (give date) _____ kidney disease (infectious)
NO YES (give date) _____ liver disease (mononucleosis, hepatitis)
10. Do you or have you ever been told by a doctor that you have asthma? **NO YES** (list medication) _____
11. Do you or have you ever had a hernia or “rupture”? **NO YES** Has it been repaired _____ Date _____
12. Have you ever been “knocked out” (unconscious) in the past 3 years? **NO YES** (list dates) _____
13. Have you had a concussion or other head injury in the past 3 years? **NO YES** (list dates) _____
14. Have you stayed overnight in a hospital due to a head injury? **NO YES** (list dates) _____
15. Do you wear glasses or contacts during competition? **NO YES**
16. 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)
17. Have you had a broken bone or fracture in the past 2 years? **NO YES** R ___ or L ___
What bone(s) _____ Dates _____
18. Have you ever had a shoulder injury in the past 2 years that disabled you for a week or longer? (dislocation, Separation, etc) **NO YES** R ___ or L ___ Type of injury _____ Date _____
19. Have you ever had shoulder surgery? **NO YES** R ___ or L ___ What was done & why? _____ Date _____
20. Have you ever injured your back? **NO YES** Type of Injury _____ Date _____
21. Have you injured your knee in the past two years? **NO YES**
22. Have you been told by a doctor or athletic trainer that you injured the cartilage in your knee? **NO YES** R ___ or L ___
Date _____
23. Have you been told by a doctor or athletic trainer that you injured the ligaments in your knee? **NO YES** R ___ or L ___
Date _____
24. Have you ever had knee surgery? **NO YES** R ___ or L ___ What was done? _____ Date _____
25. Have you had a severe ankle sprain in the past 2 years? **NO YES** R ___ or L ___
26. Do you have a pin, screw, or plate in your body? **NO YES** Where in your body? _____ Date _____
27. Do you have other conditions that we should be aware of (i.e ulcers, pregnancy, food or insect allergies, tendinitis, etc.)?
NO YES (specify and give details) _____
28. **DATE OF YOUR LAST IMMUNIZATION:** Tetanus _____ Polio _____ Mumps _____ Rubella _____ Measles _____
(Do not send a copy of your complete shot record)

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

Athlete’s Signature _____ Parent Signature _____ Date _____