



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. 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 & 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 you have sickle cell anemia? NO YES
8. Have you ever been told by a doctor that you have sickle cell trait? NO YES
9. Do you have or have you ever had high blood pressure? NO YES
(List medication)
10. 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
11. Do you or have you ever been told by a doctor that you have asthma? NO YES
(List medications)
12. Do you or have you ever had a hernia or "rupture"? NO YES
Has it been repaired?
13. Have you been "knocked out" (unconscious) in the past 3 years? NO YES
(List dates)
14. Have you had a concussion or other head injury in the past 3 years? NO YES
(List dates)
15. Have you stayed overnight in a hospital due to a head injury? NO YES
(List dates)

16. Have you ever had a neck injury involving bones, nerves or discs that disabled you for a week or longer? Type of injury _____ Dates _____ NO YES
17. Do you wear glasses or contacts during competition? NO YES
18. 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)
19. Have you had a broken bone or fracture in the past 2 years? R or L ___ What bone? _____ Dates _____ NO YES
20. Have you had a shoulder injury in the past 2 years that disabled you for a week or longer (dislocation, separation, etc.) R or L ___ Type of injury _____ Dates _____ NO YES
21. Have you ever had shoulder surgery? R or L ___ What was done & why? _____ Date _____ NO YES
22. Have you ever injured your back? Type of injury _____ Date _____ NO YES
23. Do you have back pain? SELDOM, OCCASIONALLY, FREQUENTLY, WITH VIGOROUS EXERCISE, WITH HEAVY LIFTING NO YES (circle those which apply)
24. Have you injured your knee in the past 2 years? R or L ___ What was done & why? _____ Date _____ NO YES
25. Have you been told by a doctor or athletic trainer that you injured the cartilage in your knee? R or L ___ Date _____ NO YES
26. Have you been told by a doctor or athletic trainer that you injured the ligaments in your knee? R or L ___ Date _____ NO YES
27. Have you ever had knee surgery? R or L ___ What was done & why? _____ Date _____ NO YES
28. Have you had severe ankle sprain in the past 2 years? NO YES
29. Do you have a pin, screw, or plate in your body? Where in your body? _____ Date _____ NO YES
30. Do you have any other conditions that we should be aware of (i.e. ulcers, pregnancy, food or insect allergies, tendinitis, etc.)? (specify & give details) NO YES
31. Please give the date of your last immunization for: tetanus _____ polio _____ mumps _____ rubella _____ measles _____

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