

UNITED STATES YOUTH SOCCER
Proud Member of the United States Soccer Federation, Inc.
GODP 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?
(Please List) | NO YES |
| 2. | Do you take any prescribed medication on a permanent or semi-permanent basis (steroids, birth control pills, anti-inflammatories, antibiotics, etc.)?
(List & give reason) | NO YES |
| 3. | Have you ever had a seizure? | NO YES |
| 4. | Have you ever been told by a doctor that you have epilepsy?
(List medication) | NO YES |
| 5. | Have you ever been treated for diabetes? | NO YES |
| 6. | Have you ever been told by a doctor that you were anemic?
When? | NO YES |
| 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?
(List medication) | NO YES |
| 9. | Do you have or have you ever had the following diseases?
- Heart disease (heart murmur, rheumatic fever) Give date _____
- Lung disease (pneumonia) Give date _____
- Kidney disease (infections) Give date _____
- Liver disease (mononucleosis, hepatitis) Give date _____ | NO YES
NO YES
NO YES
NO YES |
| 10. | Do you or have you ever been told by a doctor that you have asthma?
(List medications) | NO YES |
| 11. | Do you or have you ever had a hernia or "rupture"?
Has it been repaired? | NO YES
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?
Dates | NO YES |
| 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

Form 1008 (rev 4/06)