



UNITED STATES YOUTH SOCCER ASSOCIATION, INC.

Proud Member of the United States Soccer Federation, Inc.

OLYMPIC DEVELOPMENT PROGRAM

MEDICAL HISTORY QUESTIONNAIRE

NAME: LAST FIRST MIDDLE

ADDRESS: STREET CITY STATE ZIP

DOB 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
2. Do you take any prescribed medication on a permanent or semi-permanent basis... NO YES
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
5. Have you been treated for diabetes? NO YES
6. Have you ever been told by a doctor that you were anemic? NO YES
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
10. Do you have or have you ever had the following diseases? NO YES
11. Do you have or have you been told by a doctor that you have asthma? NO YES
12. Do you or have you ever had a hernia or "rupture"? NO YES
13. Have you been "knocked out" (unconscious) in the past 3 years? NO YES
14. Have you had a concussion or other head injury in the past 3 years? NO YES

15. Have you stayed overnight in a hospital due to a head injury?
(List dates) NO YES
16. Have you ever had a neck injury involving bones, nerves of discs that disabled you for a week or longer? Type of injury
(List 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, REMOVEABLE PARTIAL PLATE, FULL PLATE, PERMANENT CROWN OR JACKET? NO YES
(circle all that 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
(List dates) NO YES
21. Have you ever had shoulder surgery?
R or L? What was done and Why? _____ Date NO YES
22. Have you ever injured your back?
Type of injury _____ Date NO YES
23. Do you have back pain?
SELDOM, OCCASIONNALLY, FREQUENTLY, WITH VIGOROUS EXERCISE, WITH HEAVY LIFTING NO YES
(circle all that apply)
24. Have you injured your knee in the past 2 years?
R or L? What was done and Why? _____ Date NO YES
25. Have you been told by a doctor or an 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 an 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 and Why? _____ Date NO YES
28. Have you had a 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, tendonitis, etc.)? (Specify and 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