US YOUTH SOCCER ASSOCIATION, IN.
REGION II OLYMPIC DEVELOPMENT PROGRAM

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ DATE OF BIRTH: _____/_____/_____

ADDRESS: _____ CITY: _____ST: _____ ZIP: _____

EMERGENCY CONTACT: _____PH: HM (____)_____ WK (_____)_____

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.)? YES NO
   If yes, please list_____
2. Do you take any prescribed medication on a permanent or semi-permanent basis (steroids, birth control pills, antibiotics, anti-inflammatories, etc.)? YES NO

   If yes, list and give reasons _____
3. Have you ever had an epileptic seizure? YES NO
4. Have you ever been told by a doctor that you had epilepsy? YES NO

   If yes, list medication _____
5. Have you ever been treated for diabetes? YES NO

   If yes, list medication _____
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 traits? YES NO
9. Do you have or have you ever had high blood pressure? YES NO
   If yes, list medications _____
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 (infections) YES NO Give Date _____
    - Liver Disease (mononucleosis, hepatitis) YES NO Give Date _____
11. Have you ever been told by a doctor that you have asthma? YES NO

    If yes, list medication _____
12. Do you have or have you ever had a hernia or "rupture"? Has it been repaired? YES NO
13. Have you ever been "knocked out" (unconscious) in the past 3 years? YES NO

    If yes, list dates _____
14. Have you ever had a concussion or other head injury in the past 3 years? YES NO

    If yes, list dates _____

PLEASE TURN PAGE OVER AND COMPLETE THE OTHER SIDE.

15. Have you ever stayed overnight in a hospital due to a head injury? YES ◯ NO ◯

If yes, list dates _____

16. Have you ever had a neck injury involving bones, nerves or discs that disabled you 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 ◯

If yes, check all that apply –

_____ Removable retainer _____ Permanent Retainer _____ Removable Partial Plate

_____ Full Plate _____ Braces _____ Permanent Crown/Jacket

19. Have you had a broken bone or fracture in the past 2 years? YES ◯ NO ◯

If yes, R or L? _____ Which bone? _____ Dates _____

20. Have you ever had a shoulder injury (dislocation, separation, etc.) in the past 2 years that disabled you a week or longer? YES ◯ NO ◯

If yes, R or L? _____ Type of Injury _____ Dates _____

21. Have you ever had shoulder surgery? YES ◯ NO ◯

If yes, R of L? _____ What was done and why? _____ Dates _____

22. Have you ever injured your back? YES ◯ NO ◯ If yes, give dates _____

23. Do you have back pain? YES ◯ NO ◯ If yes, check those that apply –

☐ Seldom ☐ Occasionally ☐ Frequently ☐ With Vigorous Exercise ☐ With heavy lifting

24. Have you injured your knee in the past two years? YES ◯ NO ◯ If yes, R or L? _____

25. Have you ever been told by a doctor or athletic trainer that you injured the cartilage in your knee? YES ◯ NO ◯

If yes, R or L? _____ Dates _____

26. Have you ever been told by a doctor or athletic trainer that you injured the ligaments in your knee? YES ◯ NO ◯

If yes, R or L? _____ Dates _____

27. Have you ever had knee surgery? YES ◯ NO ◯

If yes, R or L? _____ What was done? _____ Dates _____

28. Have you had a severe ankle sprain in the past 2 years? YES ◯ NO ◯

29. Do you have a pin, screw, or plate in your body? YES ◯ NO ◯

If yes, where? _____ Dates _____

30. Do you have any other conditions we should be aware of, i.e. ulcers, pregnancy, food or insect allergies, tendonitis?

YES ◯ NO ◯ If yes, specify the condition and give details. _____

_____

31. Please give the dates of your last immunization for the following.

Polio _____ Tetanus _____ Mumps _____ Rubella _____ Measles _____

THE QUESTIONS ON BOTH SIDES OF THIS FORM HAVE BEEN ANSWERED COMPLETELY AND TRUTHFULLY TOTHE BEST OF MY KNOWLEDGE.

_____ _____ _____ _____

Signature of Player *Date* *Signature of Parent/Legal Guardian* *Date*