

## MEDICAL HISTORY QUESTIONNAIRE –US YOUTH SOCCER REGION IV ODP

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE I. \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SEX\_ M\_\_\_ F\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ HM PH (\_\_\_\_) \_\_\_\_\_ WK 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. Have you ever been told by a doctor that you have sickle cell trait? **NO YES**
9. Do you or have you ever had high blood pressure? **NO YES** (List medication) \_\_\_\_\_
10. 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)
11. Do you or have you ever been told by a doctor that you have asthma? **NO YES** (list medication) \_\_\_\_\_
12. Do you or have you ever had a hernia or "rupture"? **NO YES** Has it been repaired \_\_\_\_\_ Date \_\_\_\_\_
13. Have you ever 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 bonesm nerves or disks that disables you for a week or longer  
**NO YES** Type of injury \_\_\_\_\_ Dates \_\_\_\_\_
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? **NO YES** R\_\_\_ or L\_\_\_  
What bone(s) \_\_\_\_\_ Dates \_\_\_\_\_
20. 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 \_\_\_\_\_
21. Have you ever had shoulder surgery? **NO YES** R\_\_\_ or L\_\_\_ What was done & why? \_\_\_\_\_ Date \_\_\_\_\_
22. Have you ever injured your back? **NO YES** Type of Injury \_\_\_\_\_ Date \_\_\_\_\_
23. Do you have back pain? **NO YES** (circle those that apply) SELDOM, OCCASIONALLY, FREQUENTLY, WITH VIGOROUS EXERCISE, WITH HEAVY LIFTING
24. Have you injured your knee in the past two years? **NO YES**
25. Have you been told by a doctor or athletic trainer that you injured the cartilage in your knee? **NO YES** R\_\_\_ or L\_\_\_  
Date \_\_\_\_\_
26. Have you been told by a doctor or athletic trainer that you injured the ligaments in your knee? **NO YES** R\_\_\_ or L\_\_\_  
Date \_\_\_\_\_
27. Have you ever had knee surgery? **NO YES** R\_\_\_ or L\_\_\_ What was done? \_\_\_\_\_ Date \_\_\_\_\_
28. Have you had a severe ankle sprain in the past 2 years? **NO YES** R\_\_\_ or L\_\_\_
29. Do you have a pin, screw, or plate in your body? **NO YES** Where in your body? \_\_\_\_\_ Date \_\_\_\_\_
30. 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) \_\_\_\_\_
31. **DATE OF YOUR LAST IMMUNIZATION:** Tetanus \_\_\_\_\_ Polio \_\_\_\_\_ Mumps \_\_\_\_\_ Rubella \_\_\_\_\_ Measles \_\_\_\_\_

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

Athlete's Signature \_\_\_\_\_ Parent Signature \_\_\_\_\_ Date \_\_\_\_\_