

**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.  | Do you have allergies to medicines, pollen, foods, and/or stinging insects?<br>(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.)?<br>(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?<br>(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?<br>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?<br>(List medication)   | NO YES                               |
| 9.  | Do you have or have you ever had the following diseases?<br>- Heart disease (heart murmur, rheumatic fever)      Give date _____<br>- Lung disease (pneumonia)                                      Give date _____<br>- Kidney disease (infections)                                      Give date _____<br>- Liver disease (mononucleosis, hepatitis)                      Give date _____ | NO YES<br>NO YES<br>NO YES<br>NO YES |
| 10. | Do you or have you ever been told by a doctor that you have asthma?<br>(List medications)  | NO YES                               |
| 11. | Do you or have you ever had a hernia or "rupture"?<br>Has it been repaired?  | NO YES<br>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?<br>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