OLYMPIC DEVELOPMENT PROGRAM
MEDICAL HISTORY QUESTIONNAIRE

LAST NAME____FIRST NAME____________________________MIDDLE INITIAL__________

ADDRESS____CITY__________________________STATE__________ZIP____________

DATE OF BIRTH_______-_______-_______ SEX _____M _____F

EMERGENCY CONTACT__________________________________HM PH (_____)___________________WK PH (_____)__________________

PLEASE CIRCLE EITHER **"YES"** OR **"NO"** TO ALL QUESTIONS AND PROVIDE ADDITIONAL DETAILS WHERE REQUESTED. YOU MAY PUT DETAILS ON THE BACK OF THIS FORM IF NEEDED. ALL INFORMATION IS CONFIDENTIAL.

1) ARE YOU ALLERGIC TO ANY MEDICATION (ASPIRIN, PENICILLIN, SULFA, ETC)? **YES NO** (LIST)______________________________
2) DO YOU TAKE ANY PRESCRIBED MEDICATION ON A PERMANENT BASIS OR SEMI-PERMANENT BASIS (STEROIDS, BIRTH CONTOL PILLS, ANIT-INFLAMMATORIES, ANTIBIOTICS, ETC)? **YES NO** (LIST & GIVE REASON)______________________________
3) HAVE YOU EVER HAD ANY EPILEPTIC SIEZURE? **YES NO**
4) HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE EPILEPSY? **YES NO** (LIST MEDICATION)______________________
5) HAVE YOU EVER BEEN TREATED FOR DIABETES? **YES NO**
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 TRAIT? **YES NO** ______________________________
9) DO YOU HAVE OR HAVE YOU EVER HAD HIGH BLOOD PRESSURE? **YES NO** (LIST MEDICATION)______________________
10) DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING DISEASES?
    HEART DISEASE (HEART MURMER, RHEUMATIC FEVER) **YES NO** (GIVE DATE)______________________________
    LUNG DISEASE (PNEUMONIA) **YES NO** (GIVE DATE)______________________________
    KIDNEY DISEASE (INFECTIOUS) **YES NO** (GIVE DATE)______________________________
    LIVER DISEASE (MONONUCLEOSIS, HEPATITIS) **YES NO** (GIVE DATE)______________________________
11) DO YOU HAVE OR HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE ASTHMA? **YES NO** (LIST MEDICATION)______________
12) DO YOU HAVE OR HAVE YOU EVER HAD A HERNIA OR "RUPTURE"? **YES NO** HAS IT BEEN REPAIRED?______________DATE__________
13) HAVE YOU EVER BEEN "KNOCKED OUT"(UNCONSCIOUS) IN THE PAST 3 YEARS? **YES NO** (LIST DATES)____________________
14) HAVE YOU EVER HAD A CONCUSSION OR OTHER HEAD INJURY IN THE PAST 3 YEARS? **YES NO** (LIST DATES)______________
15) HAVE YOU STAYED OVERNIGHT IN THE HOSPITAL DUE TO A HEAD INJURY? **YES NO** (LIST DATES)______________________
16) HAVE YOU EVER HAD A NECK INJURY INVOLVING BONES, NERVES, OR DISKS THAT DISABLED YOU FOR 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** (CIRCLE THOSE WHICH APPLY) PERMANENT BRIDGE, BRACES, REMOVABLE RETAINER, PERMANENT RETAINER, REMOVABLE PARTIAL PLATE, FULL PLATE, PERMANENT CROWN OR JACKET?
19) HAVE YOU HAD A BROKEN BONE OR FRACTURE IN THE PAST 2 YEARS? **YES NO** _____RIGHT OR_____LEFT
    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) **YES NO** _____RIGHT OR_____LEFT TYPE OF INJURY______________________________DATE________________
21) HAVE YOU EVER HAD SHOULDER SURGERY? **YES NO** _____RIGHT OR _____LEFT DATE______________________________
    WHAT WAS DONE AND WHY?____
22) HAVE YOU EVER INJURED YOUR BACK? **YES NO** TYPE OF INJURY______________________________DATE________________
23) DO YOU HAVE BACK PAIN? **YES NO** (CIRCLE THOSE THAT APPLY) SELDOM, OCCASIONALY, FREQUENTLY, WITH VIGOROUS EXERCISE, WITH HEAVY LIFTING
24) HAVE YOU INJURED YOUR KNEE IN THE PAST 2 YEARS? **YES NO** _____RIGHT OR _____LEFT DATE______________________
25) HAVE YOU BEEN TOLD BY A DOCTOR OR ATHLETIC TRAINER THAT YOU INJURED THE CARTILAGE IN YOUR KNEE? **YES NO**
    _____RIGHT OR _____LEFT DATE________________________
26) HAVE YOU BEEN TOLD BY A DOCTOR OR ATHLETIC TRAINER THAT YOU INJURED THE LIGAMENTS IN YOUR KNEE? **YES NO**
    _____RIGHT OR _____LEFT DATE________________________
27) HAVE YOU HAD KNEE SURGERY? **YES NO** _____RIGHT OR _____LEFT WHAT WAS DONE?____________________DATE__________
28) HAVE YOU HAD A SEVERE ANKLE SPRAIN IN THE PAST 2 YEARS? **YES NO** _____RIGHT OR _____LEFT DATE__________
29) DO YOU HAVE A PIN, SCREW, OR PLATE IN YOUR BODY? **YES NO** LOCATED WHERE____________________DATE__________
30) DO YOU HAVE OTHER CONDITIONS THAT WE SHOULD BE AWARE OF (I.E. ULCERS, PREGNANCY, FOOD OR INSECT ALLERGIES, TENDINITIS, ETC)? **YES NO** (SPECIFY & GIVE DETAILS)______________________________________
31) DATE OF LAST IMMUNIZATION: _______TETANUS _______POLIO _______MUMPS _______RUBELLA ________MEASLES

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

PARENT/GUARDIAN SIGNATURE____**DATE**____________________

ATHLETE'S SIGNATURE____**DATE**____________________