**UNITED STATES OLYMPIC EDUCATION CENTER**

**ATHLETE MEDICAL HISTORY QUESTIONNAIRE**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SPORT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GENDER: FEMALE \_\_\_\_\_\_\_ MALE \_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMERGENCY CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHONE: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please circle "Yes" or "No" and provide additional details where requested on this form.**

**All information will be confidential.**

1. Have you had a medical illness or injury since your last check up or sports physical? Yes No

2. Do you have an ongoing or chronic illness? Yes No

3. Are you allergic to any medication (aspirin, penicillin, sulfa, etc.)? Yes No

(List\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

4. Do you have any food allergies? Yes No

(List\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

5. Do you have any seasonal allergies that require medical treatment? Yes No

(List\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

6. Are you allergic to insect bites or stings? Yes No

(List \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

7. Do you take any over the counter medication(s)? Yes No

(List\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

8. Do you take any prescribed medication on a permanent or semi-permanent basis Yes No

(steroids, birth control pills, anti-inflammatories, antibiotics, etc.)?

(List\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

9. Do you use an inhaler? Yes No

(List\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

10. Do you take any over the counter dietary supplements

(herbs, vitamins, minerals, protein)? Yes No

(List\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

11. Have you ever taken any dietary supplements or vitamins to help you gain or lose weight or improve your performance?

Yes No

(List\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

12. Do you ever have chest tightness? Yes No

13. Do you ever have wheezing? Yes No

***PLEASE CONTINUE TO NEXT PAGE…..***

14. Do you ever have itchy eyes? Yes No

15. Do you ever have itching of the nose or throat or sneezing spells? Yes No

16. Does running ever cause chest tightness or cough or wheezing or prolonged

shortness of breath? Yes No

17. Have you ever had chest tightness, cough, wheezing, asthma or other chest (lung)

problems which made it difficult for you to perform in sports? Yes No

18. Have you ever missed school, work or practice because of chest tightness or cough

or wheezing or prolonged shortness of breath? Yes No

19. If you have been told you have asthma, what medication(s) have you taken to treat it?

(List\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

20. Have you ever had a rash or hives develop during or after exercise? Yes No

21. Have you ever had a seizure? Yes No

(List medication(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

22. Have you ever been told that you have epilepsy? Yes No

(List medication(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

23. Do you have or have you ever been treated for diabetes? Yes No

(List medication(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

24. Have you ever been told that you were anemic? Yes No

(When\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

25. Have you ever been told that you have sickle cell anemia? Yes No

26. Have you ever been told by a physician you have the sickle cell trait? Yes No

27. Have you ever become ill from exercising in the heat? Yes No

28. Have you ever passed out in the heat? Yes No

29. Have you ever had heat or muscle cramps? Yes No

30. Have you ever been told to give up sports because of health problem? Yes No

31. Has anyone in your family under age 50 died suddenly? Yes No

Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

32. Do you have or have you ever had high blood pressure? Yes No

(List medication(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

33. Do you have or have you ever had high cholesterol? Yes No

34. Do you have trouble breathing or do you cough during or after activity? Yes No

***PLEASE CONTINUE TO NEXT PAGE…..***

35. Have you ever been dizzy during or after exercise? Yes No

36. Have you ever fainted or passed out when exercising? Yes No

37. Have you ever had chest pain during or after exercise? Yes No

38. Do you have or have you ever had racing of your heart or skipped heartbeats? Yes No

39. Do you get tired more quickly than your friends do during exercise? Yes No

40. Do you have or have you ever been told you have a heart murmur? Yes No

(Give date(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

41. Do you have a heart arrhythmia? Yes No

(List medication and dosage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

42. Do you have a family history of heart disease? Yes No

Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

43. Do you have any other history of heart disease? (angina, arrhythmia, valve disease) Yes No

Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

44. Have you had a severe viral infection (for example myocarditis or mononucleosis)

within the last month? Yes No

45. Do you have or have you ever had rheumatic fever? Yes No

(Give date(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

46. Do you have or have you ever had lung disease (pneumonia)? Yes No

(Give date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

47. Do you have or have you ever had kidney disease (infections)? Yes No

(Give date(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

48. Do you have or have you ever had liver disease (mononucleosis, hepatitis)? Yes No

(Give date(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

49. Do you or have you ever had a hernia or “rupture”? Yes No

Has it been repaired? Yes No

50. Do you have any current skin problems (for example, itching, rashes, acne, warts,

fungus, or blisters)? Yes No

51. Have you been “knocked out,” become unconscious, or lost your memory? Yes No

(Give date(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

52. Have you had a concussion or other head injury? Yes No

(Give date(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

***PLEASE CONTINUE TO NEXT PAGE…..***

53. Have you ever had your head or neck x-rayed? Yes No

54. Have you stayed overnight in a hospital due to head injury? Yes No

(Give date(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

55. Do you have frequent or severe headaches? Yes No

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

you for a week or longer? Yes No

(Type of injury\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

57. Have you ever had numbness or tingling in your arms, hands, legs, or feet? Yes No

58. Have you ever had a stinger, burner, or pinched nerve? Yes No

59. Have you ever injured your back? Yes No

(Type of injury\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

60. Do you have back pain? Yes No

(Circle those which apply: seldom / occasionally / frequently / with vigorous exercise / with heavy lifting )

61. Do you want to weigh more or less than you do now? Yes No

62. Do you lose weight regularly to meet weight requirements for your sport? Yes No

63. Do you feel stressed out? Yes No

64. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?

Yes No

If yes, circle which apply and explain.

( head / neck / back / chest / shoulder / upper arm / elbow / forearm / wrist / hand / finger / hip / thigh / knee / shin/calf / ankle / foot)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

65. Have you had a broken bone or fracture? R or L Yes No

(What bone(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

66. Have you had a shoulder injury that disabled you for a week or longer Yes No

(dislocation, separation, etc.)?

(Type of injury\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

67. Have you ever had a shoulder surgery? R or L Yes No

(What was done & why\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

68. Does your shoulder routinely/occasionally dislocate (come out of place)/sublux? Yes No

69. Have you injured your knee? R or L Yes No

***PLEASE CONTINUE TO NEXT PAGE…..***

70. Have you been told by a doctor or athletic trainer that you injured the

cartilage in your knee? R or L Yes No

(Give date(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

71. Have you been told by a doctor or athletic trainer that you injured the

ligaments in your knee? R or L Yes No

(Give date(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

72. Have you ever had knee surgery? R or L Yes No

(What was done \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

73. Have you had a severe ankle sprain? R or L Yes No

74. Do you have a pin, screw or plate in your body? Yes No

(Where in your body\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

75. Have you had any surgery? Yes No

Specify and give details:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

76. Do you use any special protective or corrective equipment or devices that are not usually used for your sport (for example, knee brace, special neck roll, foot orthotics, hearing aid)?

Yes No

77. Have you had any problems with your eyes or vision? Yes No

78. Do you wear glasses, contacts or protective eyewear during competition? Yes No

79. Do you have a hearing loss? R= \_\_\_\_\_\_\_\_\_\_ L= \_\_\_\_\_\_\_\_\_\_ Yes No

% of hearing loss? R= \_\_\_\_\_\_\_\_\_\_ L= \_\_\_\_\_\_\_\_\_\_

Do you use an appliance? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

80. Do you wear any of the following dental appliances? Yes No

(Circle those which apply: permanent bridge / removable retainer / removable partial plate permanent crown or jacket / braces / permanent retainer / full plate )

81. Are you missing one of a set of paired organs (kidney, eyes, etc.)? Yes No

(List\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

82. Do you now or have you ever had herpes? Yes No

**FEMALES ONLY**

83. When was your first menstrual period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

84. When was your most recent menstrual period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

85. How much time do you usually have from the start of one period to the start of another?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***PLEASE CONTINUE TO NEXT PAGE…..***

86. How many periods have you had in the last year? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

87. What was the longest time between periods in the last year? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

88. Are you pregnant, or do you suspect that you may be pregnant? Yes No

*(If the answer is “Yes,” this does not necessarily preclude your participation from your sport, however you must present a clearance form you physician stating that your sport participation will not be detrimental to the pregnancy.)*

89. Do you have any other conditions that we should be aware of (i.e. ulcers, tendonitis, etc.)?

Yes No

Specify and give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

90. Please give the date of your last immunizations:

Tetanus\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Polio\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hepatitis B\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

91. Please give the date of your last measles, mumps, rubella and chicken pox shots:

Measles\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mumps\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rubella\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chicken Pox\_\_\_\_\_\_\_\_\_\_\_\_\_\_

92. Which of the following dietary supplements have you taken **during the past year**?

\_\_\_\_\_\_\_\_\_\_Multi-vitamin/minerals \_\_\_\_\_\_\_\_\_\_Protein drinks or bars

\_\_\_\_\_\_\_\_\_\_Individual vitamin (e.g. vitamin C, etc.) \_\_\_\_\_\_\_\_\_\_Energy drinks or bars

\_\_\_\_\_\_\_\_\_\_Individual mineral (e.g. iron, calcium, etc.) \_\_\_\_\_\_\_\_\_\_Creatine

\_\_\_\_\_\_\_\_\_\_Protein powders or pills \_\_\_\_\_\_\_\_\_\_Amino Acid or powders

\_\_\_\_\_\_\_\_\_\_Herbals (e.g. Ginseng, Echinacea, etc.) \_\_\_\_\_\_\_\_\_\_Others – please list:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

93. If you took any dietary supplements during the past year, how frequently did you take them?

\_\_\_\_\_\_\_\_\_\_\_\_ Daily \_\_\_\_\_\_\_\_\_\_\_\_ Occasionally

\_\_\_\_\_\_\_\_\_\_\_\_ Once a week \_\_\_\_\_\_\_\_\_\_\_\_ Several times a week

\_\_\_\_\_\_\_\_\_\_\_\_ Only at specific times (travel, training, etc.)

94. Check the reasons for using dietary supplements **during the past year**:

\_\_\_\_\_\_\_\_\_\_\_\_ To make up for an inadequate diet \_\_\_\_\_\_\_\_\_\_\_\_ To lose weight

\_\_\_\_\_\_\_\_\_\_\_\_ To treat a medical condition or injury \_\_\_\_\_\_\_\_\_\_\_\_ To have more energy

\_\_\_\_\_\_\_\_\_\_\_\_ To increase muscle mass/gain weight \_\_\_\_\_\_\_\_\_\_\_\_ To enhance my performance

\_\_\_\_\_\_\_\_\_\_\_\_ To prevent illness and disease \_\_\_\_\_\_\_\_\_\_\_\_ No specific reason

**I hereby state that the questions on this form have been answered completely and truthfully to the best of my knowledge.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of athlete Date**

**Noteworthy medical conditions/issues as per Medical Staff review:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Staff signature Date**