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 (steroids, birth control pills, anti-inflammatories, antibiotics, etc.)? Yes No
(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 (dislocation, separation, etc.)? Yes No
(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
_________Individual vitamin (e.g. vitamin C, etc.)
_________Individual mineral (e.g. iron, calcium, etc.)
_________Protein powders or pills
_________Herbals (e.g. Ginseng, Echinacea, etc.)

_________Protein drinks or bars
_________Energy drinks or bars
_________Creatine
_________Amino Acid or powders
_________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**