US Youth Soccer Olympic Development Program

Proud Member of the U.S. Soccer Federation, Inc.

BODP 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 <u>BOTH SIDES</u> OF THIS FORM. ALL INFORMATION WILL BE CONFIDENTIAL.

1. Are you allergic to any medication (aspirin, penicillin, sulfa, etc.)? NO YES
   (Please 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 & 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 you 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 have or have you ever had high blood pressure? NO YES
   (List medication)

10. Do you have or have you ever had the following diseases?
    - Heart disease (heart murmur, rheumatic fever) Give date_______________ NO YES
    - Lung disease (pneumonia) Give date_______________ NO YES
    - Kidney disease (infections) Give date_______________ NO YES
    - Liver disease (mononucleosis, hepatitis) Give date_______________ NO YES

11. Do you or have you ever been told by a doctor that you have asthma? NO YES
    (List medications)

12. Do you or have you ever had a hernia or "rupture"? NO YES
    Has it been repaired? NO YES

13. Have you been "knocked out" (unconscious) in the past 3 years? (If yes, List Date) NO YES

14. Have you had a concussion or other head injury in the past 3 years? (If yes, List Dates) NO YES

15. Have you stayed overnight in a hospital due to a head injury? (If yes, List Dates) NO YES

16. Have you ever had a neck injury involving bones, nerves or discs that disabled 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: (circle those which apply) NO YES
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?
R or L__________ What bone?____________________ Dates__________________ NO YES

20. Have you had a shoulder injury in the past 2 years that disabled you for a week or longer? NO YES
(Dislocation, separation, etc.)
R or L__________ Type of injury?_________________ Dates__________________

21. Have you ever had shoulder surgery? NO YES
R or L__________ What was done & why?____
Dates__________

22. Have you ever injured your back? NO YES
Type of injury?____ Dates__________________

23. Do you have back pain? (circle those which apply) NO YES
SELDOM, OCCASIONALLY, FREQUENTLY, WITH VIGOROUS EXERCISE, WITH HEAVY LIFTING

24. Have you injured your knee in the past 2 years? NO YES
R or L__________ What was done & why?____
Dates__________

25. Have you been told by a doctor or athletic trainer that you injured the cartilage in your knee? NO YES
R or L__________ Dates_________________________

26. Have you been told by a doctor or athletic trainer that you injured the ligaments in your knee? NO YES
R or L__________ Dates_________________________

27. Have you ever had knee surgery? NO YES
R or L__________ What was done & why?____
Dates__________

28. Have you had severe ankle sprain in the past 2 years? NO YES

29. Do you have a pin, screw, or plate in your body? NO YES
Where in your body?___________________________________ Dates__________________

30. Do you have any other conditions that we should be aware of (i.e. ulcers, pregnancy, food or insect Allergies, tendonitis, etc.)? NO YES
(Specify & give details)

31. Please give the date of your last immunization for:
tetanus_________ polio__________ mumps________ rubella________ measles________

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

Form 1008 (rev 2/97)