

OLYMPIC TRAINING CENTER ATHLETE MEDICAL HISTORY QUESTIONNAIRE

NAME: _____	SPORT: _____
DATE OF BIRTH: _____	SEX: 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.)?
(List _____) | Yes | No |
| 4. Do you have any food allergies?
(List _____) | Yes | No |
| 5. Do you have any seasonal allergies that require medical treatment?
(List _____) | Yes | No |
| 6. Are you allergic to insect bites or stings?
(List _____) | Yes | No |
| 7. Do you take any over the counter medication(s)?
(List _____) | Yes | No |
| 8. Do you take any prescribed medication on a permanent or semi-permanent basis
(steroids, birth control pills, anti-inflammatories, antibiotics, etc.)?
(List _____) | Yes | No |
| 9. Do you use an inhaler?
(List _____) | Yes | No |
| 10. Do you take any over the counter dietary supplements (herbs, vitamins, minerals, protein)?
(List _____) | Yes | No |
| 11. Have you ever taken any dietary supplements or vitamins to help you gain or lose
weight or improve your performance?
(List _____) | Yes | No |
| 12. Do you ever have chest tightness? | Yes | No |

- | | | | |
|-----|---|-----|----|
| 13. | Do you ever have wheezing? | Yes | No |
| 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?
(List medication(s) _____) | Yes | No |
| 22. | Have you ever been told that you have epilepsy?
(List medication(s) _____) | Yes | No |
| 23. | Do you have or have you ever been treated for diabetes?
(List medication(s) _____) | Yes | No |
| 24. | Have you ever been told that you were anemic?
(When _____) | Yes | No |
| 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?
Explain _____ | Yes | No |
| 32. | Do you have or have you ever had high blood pressure?
(List medication(s) _____) | Yes | No |
| 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 |
| 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) Yes No
within the last month?
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, Yes No
fungus, or blisters)?
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) _____)
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 Yes No
you for a week or longer?
(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? If yes, circle which apply and explain. Yes No
(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?
69. Have you injured your knee? R or L Yes No
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? _____
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 from your 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**?
- | | |
|--|--|
| <input type="checkbox"/> Multi-vitamin/minerals | <input type="checkbox"/> Protein drinks or bars |
| <input type="checkbox"/> Individual vitamin (e.g. vitamin C, etc.) | <input type="checkbox"/> Energy drinks or bars |
| <input type="checkbox"/> Individual mineral (e.g. iron, calcium, etc.) | <input type="checkbox"/> Creatine |
| <input type="checkbox"/> Protein powders or pills | <input type="checkbox"/> Amino acid pills or powders |
| <input type="checkbox"/> Herbals (e.g. Ginseng, Echinacea, etc.) | <input type="checkbox"/> Others – please list |
| | <input type="text"/> |
| | <input type="text"/> |
| | <input type="text"/> |
93. If you took any dietary supplements during the past year, how frequently did you take them?
- | | |
|--|---|
| <input type="checkbox"/> Daily | <input type="checkbox"/> Occasionally |
| <input type="checkbox"/> Once a week | <input type="checkbox"/> Several times a week |
| <input type="checkbox"/> Only at specific times (travel, training, etc.) | |
94. Check the reasons for using dietary supplements **during the past year**:
- | | |
|---|--|
| <input type="checkbox"/> To make up for an inadequate diet | <input type="checkbox"/> To lose weight |
| <input type="checkbox"/> To treat a medical condition or injury | <input type="checkbox"/> To have more energy |
| <input type="checkbox"/> To increase muscle mass/gain weight | <input type="checkbox"/> To enhance my performance |
| <input type="checkbox"/> To prevent illness and disease | <input type="checkbox"/> 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 Participant

Date

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

Medical Staff signature

Date