

# PARTICIPANT MEDICAL HISTORY QUESTIONNAIRE

NAME: LAST \_\_\_\_\_ FIRST \_\_\_\_\_ SPORT: \_\_\_\_\_

DATE OF BIRTH: MONTH \_\_\_\_\_ DAY \_\_\_\_\_ YEAR \_\_\_\_\_ SEX: MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PARTICIPANT'S PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_ PHONE: Cell \_\_\_\_\_ Home \_\_\_\_\_

|     | <u>Yes</u> | <u>No</u> | <u>Has the participant ever had?</u>                                       |     | <u>Yes</u> | <u>No</u> | <u>Has the participant ever had?</u>  |
|-----|------------|-----------|--|-----|------------|-----------|---|
| 1.  | _____      | _____     | Chronic or recurrent illness or injury?                                    | 18. | _____      | _____     | Asthma?   |
| 2.  | _____      | _____     | Any illness lasting more than (1) week?                                    | 19. | _____      | _____     | Epilepsy or other seizures?   |
| 3.  | _____      | _____     | Mononucleosis or Rheumatic fever?  | 20. | _____      | _____     | Diabetes?   |
| 4.  | _____      | _____     | Hospitalizations (Overnight or longer)?                                    | 21. | _____      | _____     | Herpes infection?   |
| 5.  | _____      | _____     | Surgery, other than tonsillectomy?   | 22. | _____      | _____     | Marfan Syndrome?  |
| 6.  | _____      | _____     | Missing organ (eye, kidney, testicle)?                                     | 23. | _____      | _____     | Eyeglasses or contact lenses?   |
| 7.  | _____      | _____     | Allergies to pollen, stinging insect, food, etc.?                          |     |            |           |   |
| 8.  | _____      | _____     | High blood pressure or high cholesterol?                                   |     | <u>Yes</u> | <u>No</u> | <u>Is there a history of?</u>   |
| 9.  | _____      | _____     | Heart problems (Racing, murmur, skipped beats, infections, etc.?)          | 24. | _____      | _____     | Injuries requiring medical treatment?   |
| 10. | _____      | _____     | Chest pressure or pain with exercise?                                      | 25. | _____      | _____     | Neck injury?  |
| 11. | _____      | _____     | Dizziness or fainting with exercise?                                       | 26. | _____      | _____     | Knee injury or surgery?   |
| 12. | _____      | _____     | Excessive shortness of breath with exercise?                               | 27. | _____      | _____     | Other serious joint injuries?   |
| 13. | _____      | _____     | Seizures or frequent headaches?  | 28. | _____      | _____     | Use of protective equipment or braces?  |
| 14. | _____      | _____     | Head injury, concussion, unconsciousness?                                  | 29. | _____      | _____     | Do you know your sickle cell status?  |
| 15. | _____      | _____     | Numbness, tingling or weakness in arms or legs with contact?               | 30. | _____      | _____     | Has a doctor ever denied or restricted your participation in sports for any reason? |
| 16. | _____      | _____     | Headache, memory loss, or confusion with contact?                          | 31. | _____      | _____     | Do you have any concerns that you would like to discuss with the doctor?            |
| 17. | _____      | _____     | Severe muscle cramps or become ill when exercising in the heat?            |     |            |           |   |
|     | <u>Yes</u> | <u>No</u> | <u>Family History:</u>   |     |            |           |   |
| 32. | _____      | _____     | Does anyone in your family have Marfan syndrome?                           |     |            |           |   |
| 33. | _____      | _____     | Has anyone in your family died suddenly for no apparent reason?            |     |            |           |   |
| 34. | _____      | _____     | Has anyone in your family had a heart attack at less than 55 years of age? |     |            |           |   |

Use this space to explain any "YES" answers from above (questions #1-34) or **to provide any additional information:**

35. Are you allergic to any prescription or over-the-counter medications? Do you have any food allergies? If yes, list: \_\_\_\_\_

-Do you have a therapeutic use exemption? \_\_\_\_\_

36. List all medications you are presently taking (including asthma inhalers & EpiPens) and the condition the medication is for:

A. \_\_\_\_\_ B. \_\_\_\_\_

C. \_\_\_\_\_

37. Year of last known: Tetanus (lockjaw) vaccination: \_\_\_\_\_ Meningitis vaccination: \_\_\_\_\_

38. What is the most and least you have weighed in the past year? **Most** \_\_\_\_\_ **Least** \_\_\_\_\_

39. Are you happy with your current weight? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**FOR FEMALES ONLY:**

1. How old were you when you had your first menstrual period? \_\_\_\_\_

2. In the past 12 months, what is the longest time you have gone between menstrual periods? \_\_\_\_\_

**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

**FOR ATHLETES OF MINORITY OF AGE**

This is to certify that I, as the parent/guardian of this participant, have explained to my son/daughter the aforementioned stipulated conditions and their ramifications, and I consent to his/her participation in the programs conducted at this USOTC, and consent to the provisions of medical, psychological or psychiatric care and treatment, emergency medical services, transportation, housing and meals associated with participation in programs conducted at this United States Olympic Training Center. In the event that emergency medical services are required, I hereby authorize the USOC to act to resolve such emergency without first obtaining my prior consent or the consent of the participant's next of kin or any other individual.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Name (Please Print)

\_\_\_\_\_  
Relationship