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: M / F EMERGENCY CONTACT PHONE ( ) -

PLEASE CIRCLE "YES" OR "NO" AND PROVIDE ADDITIONAL DETAILS WHERE REQUESTED ON BOTH SIDES OF THIS FORM. ALL INFORMATION WILL BE CONFIDENTIAL.

1. Are you allergic to any medication (aspirin, penicillin, sulfa, etc.)? NO YES
(List)
2. Do you take any prescribed medication on a permanent or semi-permanent basis (steroids, birth control Pills, anti-inflammatories, antibiotics, etc.)? (List & give reason) NO YES
3. Have you ever had an epileptic seizure? NO YES
4. Have you ever been told by a doctor that you have epilepsy? (List medication) NO YES
5. Have you ever been treated for diabetes? NO YES
6. Have you ever been told by a doctor that you were anemic? When? NO YES
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? (List medication) NO YES
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? (List medications) NO YES
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? (List dates) NO YES
14. Have you had a concussion or other head injury in the past 3 years? (List dates) NO YES
15. Have you stayed overnight in a hospital due to a head injury? (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? Type of injury Dates NO YES
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)
    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 (Dislocation, separation, etc.) R or L Type of injury Dates NO YES
21. Have you ever had shoulder surgery? NO YES
    R or L What was done & why? Date
22. Have you ever injured your back? Type of injury Date NO YES
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? R or L What was done & why? Date NO YES
25. Have you been told by a doctor or athletic trainer that you injured the cartilage in your knee? R or L Date NO YES
26. Have you been told by a doctor or athletic trainer that you injured the ligaments in your knee? R or L Date NO YES
27. Have you ever had knee surgery? R or L What was done & why? Date NO YES
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? Where in your body? Date NO YES
30. Do you have any other conditions that we should be aware of (i.e. ulcers, pregnancy, food or insect Allergies, tendonitis, etc.)? (Specify & give details) NO YES
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