OLYMPIC TRAINING CENTER
PARTICIPANT MEDICAL HISTORY QUESTIONNAIRE

NAME: LAST________________________________ FIRST________________________SPORT: ______________________________________

DATE OF BIRTH: MONTH__________________ DAY ___________________ YEAR ______________________ SEX: MALE_____ FEMALE____

ADDRESS: ______________________________________ CITY: _________________________________ STATE:___________ZIP: __________

EMERGENCY CONTACT:

NAME:____ PHONE: CELL_____________________________HOME______________________

	Yes	***No***	***Has the participant ever had?***
1.	______	______	Chronic or recurrent illness or injury?
2.	______	______	Any illness lasting more than (1) week?
3.	______	______	Mononucleosis or Rheumatic fever?
4.	______	______	Hospitalizations (Overnight or longer)?
5.	______	______	Surgery, other than tonsillectomy?
6.	______	______	Missing organ (eye, kidney, testicle)?
7.	______	______	Allergies to pollen, stinging insect, food, etc.?
8.	______	______	High blood pressure or high cholesterol?
9.	______	______	Heart problems (Racing, murmur, skipped beats, infections, etc.?)
10.	______	______	Chest pressure or pain with exercise?
11.	______	______	Dizziness or fainting with exercise?
12.	______	______	Excessive shortness of breath with exercise?
13.	______	______	Seizures or frequent headaches?
14.	______	______	Head injury, concussion, unconsciousness?
15.	______	______	Numbness, tingling or weakness in arms or legs with contact?
16.	______	______	Headache, memory loss, or confusion with contact?
17.	______	______	Severe muscle cramps or become ill when exercising in the heat?
18.	______	______	Asthma?
19.	______	______	Epilepsy or other seizures?
20.	______	______	Diabetes?
21.	______	______	Herpes infection?
22.	______	______	Marfan Syndrome?
23.	______	______	Eyeglasses or contact lenses?

	Yes	***No***	***Is there a history of?***
24.	______	______	Injuries requiring medical treatment?
25.	______	______	Neck injury?
26.	______	______	Knee injury or surgery?
27.	______	______	Other serious joint injuries?
28.	______	______	Use of protective equipment or braces?
29.	______	______	Do you know your sickle cell status?
30.	______	______	Has a doctor ever denied or restricted your participation in sports for any reason?
31.	______	______	Do you have any concerns that you would like to discuss with the doctor?

	Yes	***No***	***Family History:***
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:***
____
____
____
34. Are you allergic to any prescription or over-the-counter medications? If yes, list: ____
____
-Do you have a temporary use exemption? ____
35. List all medications you are presently taking (including asthma inhalers & EpiPens) and the condition the medication is for:
A.________________________________ B._______________________________________ C.______________________________
36. Year of last known: Tetanus (lockjaw) vaccination: ____________________________ Meningitis vaccination: ______________________
37. What is the most and least you have weighed in the past year? ***Most***____________________________ ***Least***________________________
38. 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**