



MEDICAL HISTORY QUESTIONNAIRE

NAME _____
LAST FIRST MIDDLE

ADDRESS _____
STREET CITY STATE ZIP

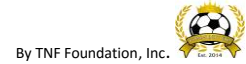
DATE OF BIRTH _____ SEX _____ EMERGENCY CONTACT _____ PHONE (____) _____

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

- 1. Are you allergic to any medication (aspirin, penicillin, sulfa, etc.)? NO YES
2. Do you take any prescribed medication on a permanent or semi-permanent basis... 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? 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? 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? NO YES
10. Do you have or have you ever had the following diseases? NO YES
11. Do you or have you ever been told by a doctor that you have asthma? NO YES



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- 12. Do you or have you ever had a hernia or "rupture"?
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? NO YES
- 17. Do you wear glasses or contacts during competition? NO YES
- 18. Do you wear any of the following dental appliances: PERMANENT BRIDGE,
BRACES, REMOVABLE RETAINER, PERMANENT RETAINER, REMOVABLE
PARTIAL PLATE, FULL PLATE, PERMANENT CROWN OR JACKET? NO YES
(circle all that apply)
- 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 NO YES
- 21. Have you ever had shoulder surgery?
R or L ___ What was done & why? Date _____ NO YES
- 22. Have you ever injured your back?
Type of injury _____ Date _____ NO YES
- 23. Do you have back pain?
SELDOM, OCCASIONALLY, FREQUENTLY, WITH VIGOROUS EXERCISE, WITH
HEAVY LIFTING NO YES
(circle those which apply)
- 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? NO YES
Where in your body? _____ Date _____
- 30. Do you have any other conditions that we should be aware of (i.e. ulcers, pregnancy, food or insect allergies, tendinitis, 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

Direct All Questions / Comments to:

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