ILLINOIS SWIMMING MEDICAL HISTORY QUESTIONNAIRE

NAME: _____
(LAST) (FIRST) (MIDDLE)

BIRTH DATE: _____ SPORT: _____ ☐MALE ☐FEMALE

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT: _____ PHONE: _____

PLEASE RESPOND TO ALL QUESTIONS ON THIS QUESTIONNAIRE AND GIVE DETAILS AS REQUESTED. ALL INFORMATION PROVIDED WILL REMAIN CONFIDENTIAL.

1. Are you allergic to any medication (aspirin, penicillin, sulfa, etc.)
   ☐ No ☐ Yes If yes, list: _____

2. Do you take any medication on a permanent/ semi-permanent basis (anti-inflammatory, antibiotics, etc.)?
   ☐ No ☐ Yes If yes, list: _____

3. Have you ever had an epileptic seizure?
   ☐ No ☐ Yes If yes, give date of last seizure_____

4. Have you ever been told by a physician you have epilepsy?
   ☐ No ☐ Yes
   If yes, are you on medication? ☐ No ☐ Yes If yes, what medication? _____

5. Have you ever been treated for diabetes?
   ☐ No ☐ Yes
   If yes, are you on medication? ☐ No ☐ Yes If yes, what medication? _____

6. Have you ever been told by a physician you were anemic?
   ☐ No ☐ Yes If yes, when? _____

7. Have you ever been told by a physician you have sickle cell anemia?
   ☐ No ☐ Yes

8. Have you ever been told by a physician 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 any of the following diseases? If yes, give dates.

    ☐ No ☐ Yes Heart Disease (heart murmur, rheumatic fever, etc.) Date: _____

    ☐ No ☐ Yes Lung Disease (pneumonia, tuberculosis, etc.) Date: _____

    ☐ No ☐ Yes Kidney Disease (infections) Date: _____

    ☐ No ☐ Yes Liver Disease (mononucleosis, hepatitis, etc.) Date: _____

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11. Have you ever been told by a physician you have asthma?
    ☐ No ☐ Yes
    If yes, are you on medication? ☐ No ☐ Yes If yes, what medication? _____

12. Have you had a hernia?
    ☐ No ☐ Yes
    If yes, has it been repaired? ☐ No ☐ Yes If yes, date repaired? _____

13. Have you ever been "knocked-out" (unconscious)?
    ☐ No ☐ Yes If yes, give date(s): _____

14. Have you ever had a concussion or other head injury?
    ☐ No ☐ Yes
    If yes, describe and give date(s): _____

15. Have you ever stayed overnight in a hospital due to a head injury?
    ☐ No ☐ Yes
    If yes, are you on medication? ☐ No ☐ Yes If yes, what medication? _____

16. Have you ever had a neck injury involving bones, nerves or discs that disabled you for a week or longer?
    ☐ No ☐ Yes
    If yes, describe and give date(s): _____

17. Do you wear glasses and /or contact lenses?
    ☐ No ☐ Yes

18. Do you wear any of the following dental appliances?

Permanent Bridge	☐ No	☐ Yes
Permanent Crown/Jacket	☐ No	☐ Yes
Full Plate	☐ No	☐ Yes
Braces	☐ No	☐ Yes
Permanent Retainer	☐ No	☐ Yes
Removable Retainer	☐ No	☐ Yes

19. Have you had a broken bone or fracture with the past five (5) years?
    ☐ No ☐ Yes
    If yes, what bone? _____ ☐ Right ☐ Left Date: _____

20. Have you had a shoulder injury in the past five (5) years that disabled you for a week or longer?
    ☐ No ☐ Yes
    If yes, type of injury?_____ ☐ Right ☐ Left Date: _____

21. Have you ever had shoulder surgery?
    ☐ No ☐ Yes
    If yes, type of surgery?_____ ☐ Right ☐ Left Date: _____

22. Have you ever injured your back?
    ☐ No ☐ Yes
    If yes, type of injury?_____ Date: _____

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23. Do you presently have back pain?
    ☐ No ☐ Yes
    If yes, check any of the following that apply:
    ☐ Occasionally
    ☐ Frequently
    ☐ With Vigorous Exercise
    ☐ With Heavy Lifting

24. Have you injured your knee in the past five (5) years?
    ☐ No ☐ Yes

25. Have you been told by a physician, therapist or athletic trainer you injured a cartilage/meniscus in your knee?
    ☐ No ☐ Yes
    If yes, type of injury?_____ ☐ Right ☐ Left Date:_____

26. Have you been told by a physician, therapist or athletic trainer you injured the ligaments in your knee?
    ☐ No ☐ Yes
    If yes, type of injury?_____ ☐ Right ☐ Left Date: _____

27. Have you ever had knee surgery?
    ☐ No ☐ Yes
    If yes, what was done?_____ ☐ Right ☐ Left Date: _____

28. Have you had a severe ankle sprain in the past five (5) years?
    ☐ No ☐ Yes

29. Do you have a metallic implant (pin, screw, plate, etc.) in your body?
    ☐ No ☐ Yes
    If yes, where?_____ Date: _____

30. Do you have any other medical conditions which we should be aware in order to help you (i.e. ulcers, food/insect allergy, pregnancy, etc.)
    ☐ No ☐ Yes
    If yes, specify and give details: _____
    _____
    _____

31. Please give the dates of your last immunization for:
32.
    Tetanus Date: _____
    Polio Date: _____
    Measles Date: _____
    Mumps Date: _____
    Rubella Date: _____

Signature: _____ Date: _____