



United States Fencing Association

Medical History Questionnaire

NAME:

DATE OF BIRTH:

EMERGENCY CONTACT:

SPORT:

SEX:

PHONE NUMBER:

Please circle 'yes' or 'no' and provide additional details as requested on both sides of the form. All information is confidential.

- NO YES Are you allergic to any medications? (Aspirin, penicillin, sulfa, etc.) Please list: _____
- NO YES Are you allergic to any foods? Please list: _____
- NO YES Are you allergic to insect bites/stings? Please list: _____
- NO YES Are you allergic to any trees, plants, or animals? Please list: _____
- NO YES Do you regularly take any over the counter and/or prescription medication? (steroids, birth control pills, anti-inflammatories, antibiotics, topical medications, sprays/inhalers, etc.) Please give reasons: _____
- NO YES Do you regularly take any vitamins, minerals, herbs, or other supplements? Please list: _____
- NO YES Have you ever been told that you have (had) asthma or exercise induced asthma? List medications: _____
- NO YES Have you ever had a seizure? Date of last seizure: _____
- NO YES Have you ever been told that you have epilepsy? List medications: _____
- NO YES Are you presently being treated for diabetes or high blood sugar? List medications: _____
- NO YES Have you ever been told that you were anemic? List dates: _____
- NO YES Have you ever been told that you have sickle cell anemia?
- NO YES Have you ever been told that you have sickle cell trait?
- NO YES Are you presently being treated for high blood pressure? List medications: _____
- NO YES Do you have or have you ever had heart disease (murmur, rheumatic fever, stenosis, etc.)?
List condition and dates: _____
- NO YES Do you have or have you ever had lung disease (pneumonia, tuberculosis, etc.)?
List condition and dates: _____
- NO YES Do you have or have you ever had kidney disease (infections, kidney stones, blood in urine, etc.)?
List condition and dates: _____
- NO YES Do you have or have you ever had liver disease (mononucleosis, hepatitis, etc.)?
List condition and dates: _____
- NO YES Do you have or have you ever had stomach disease (ulcers, bleeding, etc.)?
List condition and dates: _____
- NO YES Do you have or have you ever had frequent headaches (migraines, tension headaches)?
List condition and dates: _____
- NO YES Do you or have you ever had a hernia or "rupture"? List dates, if repaired: _____
- NO YES Have you ever been knocked out or had a concussion or other closed head injury?
List dates: _____
- NO YES Have you ever stayed overnight in a hospital due to a concussion or closed head injury?
List dates: _____

- NO YES Have you ever injured the bones, ligaments, nerves, or discs of your neck that disabled you for a week or longer: List injury/dates: _____
- NO YES Have you ever injured the bones, ligaments, nerves, or discs of your upper back that disabled you for a week or longer: List injury/dates: _____
- NO YES Have you ever injured the bones, ligaments, nerves, or discs of your low back that disabled you for a week or longer: List injury/dates: _____
- NO YES Have you ever had a broken bone or fracture? R or L? List bone/dates: _____
- NO YES Have you ever had a shoulder injury that disabled you for a week or longer (dislocation, separation, etc.)? R or L? List injury/dates: _____
- NO YES Have you ever had shoulder surgery? R or L? What was done/why? Date: _____
- NO YES Have you ever had an elbow injury that disabled you for a week or longer (dislocation, separation, etc.)? R or L? List injury/dates: _____
- NO YES Have you ever had elbow surgery? R or L? What was done/why? Date: _____
- NO YES Have you ever had a wrist or hand injury that disabled you for a week or longer (dislocation, separation, etc.)? R or L? List injury/dates: _____
- NO YES Have you ever had wrist or hand surgery? R or L? What was done/why? Date: _____
- NO YES Have you ever been told that you injured the patella, patellar tendon, or front part of your knee? R or L? List injury/dates: _____
- NO YES Have you ever been told that you injured the cartilage/meniscus in your knee? R or L? List injury/dates: _____
- NO YES Have you ever had knee surgery? R or L? What was done/why? Date: _____
- NO YES Have you ever had an ankle injury that disabled you for a week or longer (dislocation, separation, etc.)? R or L? List injury/dates: _____
- NO YES Have you ever had ankle surgery? R or L? What was done/why? Date: _____
- NO YES Do you presently have a rod, pin, screw, or plate anywhere in your body? Where? Date: _____
- NO YES Do you wear contact lenses while participating in your sport?
- NO YES Do you wear any removable dental appliance? (circle those which apply)
 REMOVABLE RETAINER REMOVABLE BRIDGE REMOVABLE PLATE
- NO YES Are you missing one of a set of paired organs (kidneys, eyes, testicles, etc.)? Specify & give details: _____
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- NO YES Do you have any other conditions of which you wish to make us aware? Specify and give details: _____

PLEASE GIVE THE DATES OF YOUR LAST IMMUNIZATIONS FOR:

Diphtheria _____ Tetanus _____ Measles _____ Influenza/Flu _____ Polio _____
 Rubella _____ Hepatitis A _____ Hepatitis B _____ _____ _____ Mumps _____

Please describe any special dietary needs that you have or any specific allergies you have to either food or medicine.

The above questions have been answered completely and truthfully to the best of my knowledge.

 Signature

 Date