GCST Medical History Questionnaire

(Parent completes for minors, voluntary information)

Swimmer Name _____
Last First Middle

Date Of Birth _____ Male Female (Circle)
Address _____ Email Address _____
_____ Cell Phone _____

Parent/Guardian _____ Parent/Guardian _____
Address _____ Address _____
_____ _____
Home Phone _____ Home Phone _____
Cell Phone _____ Cell Phone _____
Work Phone _____ Work Phone _____
Email Address _____ Email Address _____

Emergency Contact _____ Phone _____
Doctor _____ Phone _____
Dentist _____ Phone _____

Please Mark "Yes" or "No" and provide additional details where requested, if you answer "Yes" to any of the following questions.

1. Are you allergic to any medications (aspirin, penicillin, sulfa, etc.)?
   No _____ Yes _____ List _____
2. Are you allergic to anything else (foods, dogs, bee stings, etc.)?
   No _____ Yes _____ List _____
   _____
   How is this managed (medication, etc)? _____
   _____
3. Do you were glasses or contacts during competition or practice?
   No _____ Yes _____
4. Are you hearing impaired?
   No _____ Yes _____
   Do you read lips? No _____ Yes _____
   Do you wear a hearing aid? No _____ Yes _____
5. Do you wear any of the following dental appliances: (Circle)
   Permanent Bridge Braces Removable Retainer Permanent Retainer
   Removable Partial Plate Full Plate Permanent Crown
6. Have you been told by a doctor that you have asthma?
   No _____ Yes _____ List any Medications: _____
7. Do you have diabetes?
   No _____ Yes _____ Type I or Type II (Circle)
   List any Medications _____

8. Have you been told by a doctor that you have epilepsy?
   No _____ Yes _____ Type of Seizures: Grand Mal or Petite Mal (Circle)
   List any Medications _____
   What warning signs would indicate that you are about to have a seizure?
   _____

9. Have you been told by a doctor that you are anemic?
   No _____ Yes _____ List Treatment _____

10. Do you have High Blood Pressure?
    No _____ Yes _____ List any medications _____

11. Do you have or have you ever had any of the following diseases?
    Heart Disease (heart murmur, rheumatic fever, other)?
    No _____ Yes _____ Date & Details _____
    Lung Disease (pneumonia, other)?
    No _____ Yes _____ Date & Details _____
    Kidney Disease (infections, other)?
    No _____ Yes _____ Date & Details _____
    Liver Disease (Mononucleosis, hepatitis, other)?
    No _____ Yes _____ Date & Details _____

12. Have you ever had a shoulder injury? (Dislocation, separation, rotary cuff, etc.)
    No _____ Yes _____ Right or Left (Circle) Date of Injury _____
    Was surgery required? _____
    What was done and why? _____

13. Have you ever had a knee injury? (ACL, injured cartiledge, etc)
    No _____ Yes _____ Right or Left (Circle) Date of Injury _____
    Was surgery required? _____
    What was done and why? _____

14. Have you ever had a back injury?
    No _____ Yes _____ Date of Injury _____
    Was surgery required? _____
    What was done and why? _____

15. Have you ever had a concussion or other head injury in the past three years?
    No _____ Yes _____ Date of Injury _____
    Were you hospitalized? No _____ Yes _____ Date of Stay _____

16. Have you ever fractured any bones in your body?
    No _____ Yes _____ Date of Injury _____
    Which bone or bones? _____

17. Do you have any pins, screws, or plates in your body?
    No _____ Yes _____ Date _____
    Where _____

18. Have you ever had a severe ankle or wrist sprain?
    No _____ Yes _____ Date of Injury _____

19. Do you have any other conditions that we should be aware of? (Eating disorders, ulcers, tendonitis, etc)
    No _____ Yes _____ Specify and give details _____
    _____
    _____
    _____
    _____
20. Do you take any other prescribed medication on a permanent or semi-permanent basis, not listed in the answers above (steroids, anti-inflammatory medication, antibiotics, insulin, etc.)?
    No _____ Yes _____ List _____
    _____
    Reason _____
    _____
21. Please give the date of your last tetanus shots: _____
22. Any Additional Comments or Concerns?
    _____
    _____
    _____

I have answered all of the questions on this form completely and truthfully to the best of my knowledge.

_____

Signature of Athlete (or **parent** if the athlete is a minor) Date

A copy of your primary Medical Insurance Card is required. Please provide to us with this Form. Thank You.