Sports Medicine & Performance Center
UNIVERSITY OF COLORADO
IN PARTNERSHIP WITH BOULDER COMMUNITY HEALTH

2150 Stadium Drive, 2nd Floor | Boulder, CO 80309

Patient Label

CONFIDENTIAL MEDICAL QUESTIONNAIRE

Please fill out the entire form.

Patient Name: _____ DOB: _____ Age: _____

PCP: _____ Referring Provider: _____

Occupation: _____

Highest grade completed: ☐ Grade School ☐ Middle School ☐ High School ☐ College ☐ Postgraduate

Do you have any cultural or spiritual beliefs that will affect treating your condition? ☐ Yes ☐ No

If yes: _____

Do you have any physical/mental barriers that make it hard for you to learn? ☐ Yes ☐ No

If yes: _____

How do you learn best? ☐ Hearing information ☐ Reading/seeing information ☐ Having something demonstrated for you

Have you ever been abused physically, verbally, or sexually; harmed or felt threatened by someone at home/work? ☐ Yes ☐ No

CHIEF COMPLAINT

Date of injury or onset of symptoms: _____

Describe the injury or problem: _____

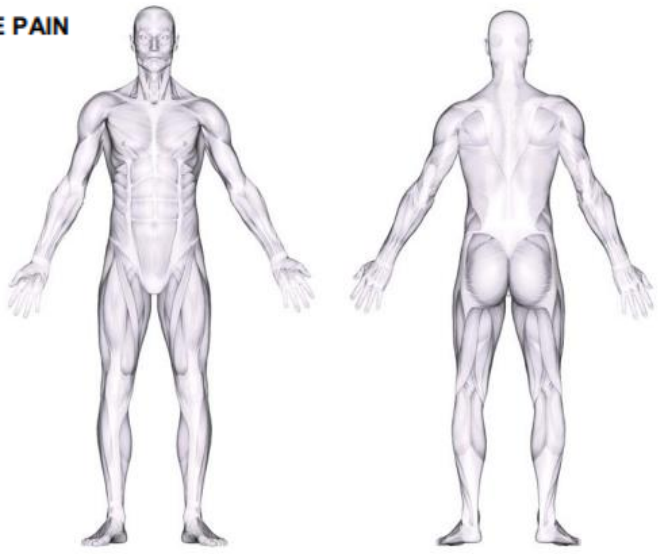
_____

Pain (check all that apply): ☐ Achy ☐ Burning ☐ Cramping ☐ Dull ☐ Pressure ☐ Radiating ☐ Sharp ☐ Squeezing ☐ Stabbing ☐ Throbbing

Using the following scale, please circle the number that best indicates the level of your current pain.

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 SEVERE PAIN

Where is your pain? Mark the drawing.



What makes it better? _____

Pain at best: **0 1 2 3 4 5 6 7 8 9 10**

What makes it worse? _____

Pain at worst: **0 1 2 3 4 5 6 7 8 9 10**

MEDICAL HISTORY

Please list all major health conditions. ☐ No major health conditions

_____ _____

_____ _____

_____ _____

_____ _____

Please detail any operations you have had. ☐ No operations

OPERATION	YEAR	SURGEON	HOSPITAL CITY AND STATE

Please list all the drugs and medications you have taken over the past 4 weeks.
(Include aspirin, birth control, supplements (i.e. vitamins), and any drug or medication with or without a prescription.)

NAME OF DRUG	DOSE	NUMBER PER DAY	SIDE EFFECTS

Please list any allergies to medications: _____

Please list any other allergies: _____

FAMILY HISTORY

The following questions concern your family medical history.

	IF LIVING		*IF DECEASED*	
	AGE(S)	MAJOR MEDICAL CONDITIONS	AGE(S) AT DEATH	CAUSE(S) OF DEATH
MOTHER				
FATHER				
SISTER(S)				
BROTHER(S)				
SON(S)				
DAUGHTER(S)				

Please list any illnesses that run in the family: _____

Does anyone in your family have any of the following problems? ☐ Heart disease ☐ High blood pressure ☐ Cancer
☐ Anesthesia complications ☐ Stroke ☐ Nerve problems ☐ Diabetes
☐ Blood problems (anemia, abnormal bleeding) ☐ Other: _____

GYNECOLOGICAL HISTORY *if applicable*

Are you pregnant? ☐ Yes ☐ No Do you use birth control? ☐ Yes ☐ No If yes, what BC to you use? _____

Have you experienced menopause or had a hysterectomy? ☐ Yes ☐ No If yes, when? _____

Date of last pap smear? _____ Date of last mammogram? _____

Age you began menstruating? _____ When was your most recent menstrual period? _____

How many periods have you had during the last 12 months? ☐ 1-6 ☐ 5-6 ☐ 7-9 ☐ 10-12 ☐ more than 12

CURRENT SYMPTOMS OR PROBLEMS

Please check any of the following that apply to you:

- ☐ Recent weigh change
- ☐ Fatigue
- ☐ Fever or chills
- ☐ Depression
- ☐ Change in appetite or thirst
- ☐ Skin rash/disease
- ☐ Vision problem/eye disease
- ☐ Nose/throat problem
- ☐ Hearing problem/ear disease
- ☐ Shortness of breath or wheezing
- ☐ Frequent cough
- ☐ Thyroid problem
- ☐ Frequent headaches
- ☐ Fainting spells
- ☐ Seizures
- ☐ Problems with coordination
- ☐ Joint stiffness, pain, or swelling
- ☐ Muscle weakness
- ☐ Difficulty in moving an arm or leg
- ☐ Swollen legs or feet
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Heart murmur
- ☐ Heart disease
- ☐ Blood disorder or blood transfusion
- ☐ Easy bleeding or bruising
- ☐ Stomach pain/heartburn
- ☐ Ulcers
- ☐ Hepatitis or gallbladder disease
- ☐ Kidney disease or kidney stones
- ☐ Change in bowel habits (includes blood in stool)
- ☐ Change in urinary habits (including pain, blood in urine, or trouble stopping or starting your urine)
- ☐ Sexually transmitted disease

HEALTH HABITS

Do you smoke cigarettes? ☐ Yes ☐ No Packs/day _____ For how long? _____ years Former smoker? ☐ Yes ☐ No

Do you smoke marijuana? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No Drinks/week _____

How would you describe your level of physical activity over the past 6 months?

- ☐ Inactive *(just daily activity)*
- ☐ Light *(some walking, gardening, occasional weekend recreational activity)*
- ☐ Moderate *(moderate exercise at least 3x/week and occasional weekend sports)*
- ☐ Vigorous *(vigorous exercise at least 3x/week and/or sports activity)*
- ☐ Intense *(competitive vigorous sports training)*

Height _____ feet/inches Weight _____ lbs

Do you consider your current weight ideal? ☐ Yes ☐ No If no, what is your ideal weight? _____ lbs

Have you had a fall within the last 3 months? ☐ Yes ☐ No Do you have a fear of falling down? ☐ Yes ☐ No

Do you have difficulty walking? ☐ Yes ☐ No

In the past two weeks, have you felt down, depressed, or hopeless? ☐ Yes ☐ No