Sports Medicine
University of Colorado

311 Mapleton Ave. Boulder, Colorado 80304

Please fill out the entire form:

Patient Label

CONFIDENTIAL MEDICAL QUESTIONNAIRE

Patient Name: _____ DOB: _____ Age: _____

Occupation: _____ PCP: _____ Referred by: _____

Highest grade completed: _____ Grade 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 every been abused physically, verbally or sexually; harmed or felt threatened by someone at home/work? ____Y ____N

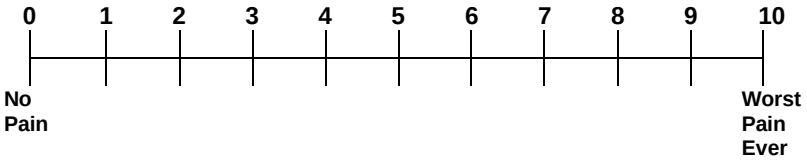
CHIEF COMPLAINT

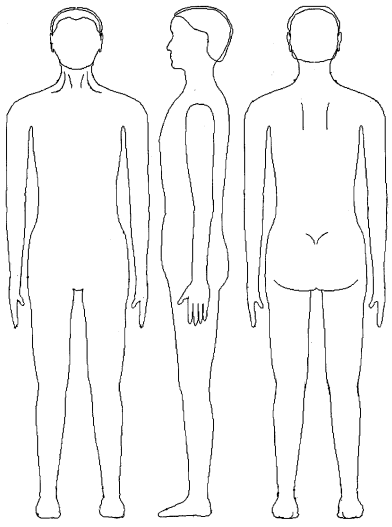
Date of injury or onset of symptoms: _____

Describe the injury or problem: _____
_____
_____

Pain: (check all that apply) ☐ dull ☐ sharp ☐ stabbing ☐ burning ☐ achy ☐ throbbing ☐ shooting ☐ squeezing ☐ pressure ☐ crampy

Using the following scale, please rate how bad your pain is today:





Where is your pain? Mark the drawing.

What makes it better? _____

What makes it worse? _____

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

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

MEDICAL HISTORY

Please detail any operations you have had. Please check here if none:_____

Operation	Year	Surgeon	Hospital/City/State
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Please list all major health conditions: (i.e. high blood pressure, diabetes, hypertension, history of blood clots):

Please check if none:_____

Health Condition		
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

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

Name of Drug	Dose	Number per Day/Week	List Any Side Effects
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

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
Father				
Mother				
Brother(s)				
Sister(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? (Please circle)

Heart disease High blood pressure Anesthesia complications Cancer Stroke

Nerve problems Blood problems (anemia, abnormal bleeding) Diabetes Other: _____

Female Patients Only: GYNECOLOGICAL HISTORY

Are you pregnant? Y N Do you use birth control? Y N If yes what: _____

Have you experienced menopause or a hysterectomy? Y N If yes, what & 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? 10-12 7-9 5-6 1-6 more

CURRENT SYMPTOMS OR PROBLEMS

Please check any of the following that apply to you:

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

HEALTH HABITS

Do you smoke cigarettes? Y N packs/day_____ For how long? _____yrs

Do you drink alcohol? Y N drinks/wk_____

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

_____ Inactive - just daily activity
_____ Light - some walking, gardening, occasional weekend recreational activity
_____ Moderate - regular (3x week) moderate exercise and occasional weekend sports
_____ Vigorous - regular (3-5x week) vigorous exercise and/or sports activity
_____ Intense - competitive vigorous sports training

Height _____ feet/inches Weight _____lbs

Do you consider your current weight ideal? Y N

If no, list your ideal weight _____

Do you have questions about healthy ways to control your weight? Y N

The following question concerns your health now and in the past. If you are unsure of how to answer the question, please provide the best answer you can.

In general, would you say your health is:

____Excellent ____Very Good ____Good ____Fair ____Poor