University of Colorado Hospital
UNIVERSITY OF COLORADO HEALTH

Sports Medicine
University of Colorado

Patient Label

CONFIDENTIAL MEDICAL QUESTIONNAIRE

Patient Name: _____ DOB: _____ Occupation: _____

CHIEF COMPLAINT/HISTORY

Date of injury or onset of symptoms: _____

Describe the injury or problem (including body part): _____

_____

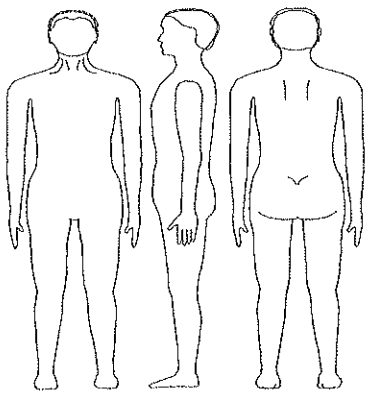
_____

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

Using scale - rate how bad your pain is **today**:

0 1 2 3 4 5 6 7 8 9 10

No Pain — **Worst Pain Ever**



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

Height _____ feet/inches Weight _____lbs

Have you fallen in the last 3 months? ☐ Yes ☐ No Do you have a fear of falling? ☐ Yes ☐ No

Do you have difficulty walking? ☐ Yes ☐ No Are you working with a physician/therapist about this problem? ☐ Yes ☐No

In the past 2 weeks have you felt depressed or hopeless? ☐Yes ☐No

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

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

Do you have any barriers to learning: (language, physical, spiritual, cultural, etc.): _____

Please list all **allergies** (medications, foods, other):_____

_____

_____

Do you currently smoke cigarettes? ☐ Yes ☐ No packs/day_____ For how long? _____yrs

If No: Are you a former smoker? ☐ Yes ☐ No Quit Date: _____

Do you use any other forms of tobacco? What form: _____ For how long? _____yrs

Do you drink alcohol? ☐ Yes ☐ No drinks/wk_____

Highest grade completed: ____ Grade School ____ High School _____College _____Postgraduate