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: _____

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: _____

CHIEF COMPLAINT

Date of injury or onset of symptoms: _____

Describe the injury or problem: _____

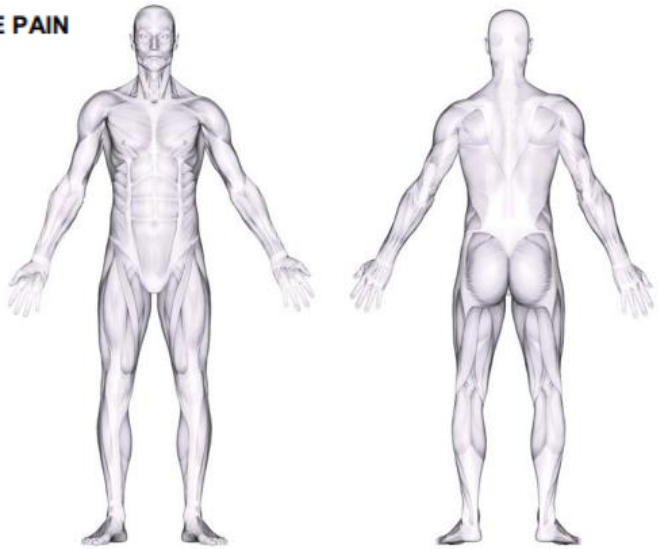
_____

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

Please list any illnesses that run in the family: _____

Does anyone in your family have any of the following problems?

☐ Anesthesia complications ☐ Blood clotting disorders (DVT or PE) ☐ Bleeding disorders (hemophilia)

☐ Cardiovascular disorders ☐ Cancer ☐ Diabetes ☐ Nerve problems ☐ Stroke

If yes, please explain: _____

HEALTH HABITS

Height _____ feet/inches Weight _____ lbs

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 _____

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

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