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.

CHIEF COMPLAINT

Date of injury or onset of symptoms: _____

Describe the injury or problem: _____

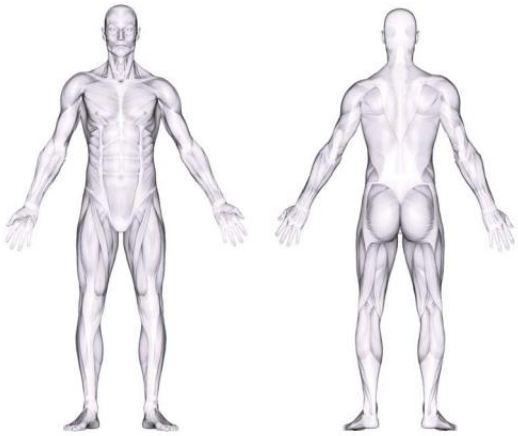
_____

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**

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
- ☐ Sexually transmitted disease
- ☐ 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
- ☐ Change in urinary habits
- ☐ Sexually transmitted disease