Patient Identification Label
Name: ______________________________
MRN: ______________________________
DOB: ______________________________
Date of Service: ______________________

CU Sports Medicine Health Assessment Questionnaire

Please Note: If you are a current patient in another practice at UCHealth and your history has already been entered into our system, you do not need to complete this form.

Social History

Tobacco Use? ☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Never
☐ Former Smoker ☐ Passive ☐Heavy Smoker ☐ Light Smoker

Types of tobacco used? ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Snuff ☐ Chew
Packs/day: _______ **Years:** _______
Quit Date:_________ Comments on your history with tobacco: ____________________

Alcohol Use? ☐ Yes ☐ No
Drinks/Week:
Glasses of wine _______
Cans of beer _______
Shots of liquor _______
Drinks containing 0.5 oz. of alcohol: ____________
Comments: ______________________________

Drug Use? ☐ Yes ☐ No
Types:
Marijuana ☐ Yes ☐ No
Methamphetamines ☐ Yes ☐ No
Cocaine ☐ Yes ☐ No
IV ☐ Yes ☐ No
Other: ______________________
Comments: __________________

Sexually Active? ☐ Yes ☐ No
Birth Control/Protection: __________________________
Partners: ☐ Female ☐ Male Comments: ______________________________

What gender do you identify as? ____
What gender was assigned to you at birth? ________________________________
What is your sexual orientation? ____

Medical History (mark all that apply)

	Yes	No	Date:
Anesthetic complications	☐	☐	
Ankylosing spondylitis	☐	☐	
Arthritis	☐	☐	
Baker's cyst	☐	☐	
Bone cyst	☐	☐	
Bursitis	☐	☐	
Cancer	☐	☐	
Carpal tunnel	☐	☐	
Fibromyositis	☐	☐	
Fractures	☐	☐	

	Yes	No	Date:
Ganglion cyst	☐	☐	
Kyphosis	☐	☐	
Osteoarthritis	☐	☐	
Osteoporosis (brittle bones)	☐	☐	
Paget's disease of bone	☐	☐	
Scoliosis	☐	☐	
Spondylolisthesis	☐	☐	
Other:			

Surgical History (mark all that apply)

	Yes	No	Date:
Abdomen surgery	☐	☐	
Ankle fracture surgery	☐	☐	
Back surgery	☐	☐	
Carpal tunnel surgery	☐	☐	
Elbow fracture surgery	☐	☐	
Elbow surgery	☐	☐	
Femur fracture surgery	☐	☐	
Foot fracture surgery	☐	☐	
Hand surgery	☐	☐	
Heart surgery	☐	☐	
Hip surgery	☐	☐	

	Yes	No	Date:
Humerus fracture surgery	☐	☐	
Joint Replacement	☐	☐	
Knee arthroscopy	☐	☐	
Knee surgery	☐	☐	
Laminectomy	☐	☐	
Shoulder arthroscopy	☐	☐	
Shoulder surgery	☐	☐	
Spinal fusion	☐	☐	
Wrist fracture surgery	☐	☐	
Other surgery:			

Family History

Relationship	Living Status	Anesthesia problems	Broken bones	Cancer	Clotting disorder	Collagen disease	Diabetes	Dislocations	Osteoporosis	Rheumatologic disease	Scoliosis	Severe sprains
Mother												
Father												
Sister												
Brother												
Daughter												
Son												
Mother's sister												
Mother's brother												
Father's sister												
Father's brother												
Mother's mother												
Mother's father												
Father's mother												
Father's father												
Other												

Details: ______________________________

Age of Onset: ______________________________

Comments: ______________________________

Marital Status: ______________________
Spouse Name: ______________________
Number of Children: ________________
Years of Education: ________________

Preferred Language: ______________________________________
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown
Race: ☐American Indian ☐ Alaska Native ☐ Asian
☐ Black or African American ☐ Pacific Islander
☐ Native Hawaiian ☐ White or Caucasian
☐ Unknown ☐ More Than One Race
☐ Other: ________________________________

Healthcare Directive

Do you have a Healthcare Directive? ☐ Yes ☐ No ☐ Unknown
Would you like to discuss a Healthcare Directive with your provider? ☐ Yes ☐ No