

18-20 Year Physical

Name: _____

Male

Is your general health OK? Yes No _____

Have you had any recent physical problems? No Yes _____

Do you have any other concerns/ worries? No Yes _____

Do you have any allergies? No Yes _____

Please list any allergies you have: _____

Are you taking any medications? No Yes _____

Please list all medications you take: _____

List any past surgeries, hospitalizations or chronic medical problems: _____

Have any family members developed any significant illnesses since your last visit? No Yes _____

Do you exercise regularly? Yes No _____

Are you still in school? Yes No _____

Do you have a job? Yes No _____

Have there been any changes in your family that concern you? No Yes _____

Do you have times when you feel down or depressed? No Yes _____

Do you have thoughts of hurting yourself? No Yes _____

What worries you? Or makes you angry? _____

Do you feel you will be successful? Yes No _____

How do you feel about your performance? Good Bad Other _____

Are there any unsecured firearms in your home? No Yes _____

Are you sexually active? No Yes _____

If you are sexually active, do you use birth control? Yes No Sometime _____

If you are having sex, what kind of birth control do you use? Condoms BCP's Other _____

Have you ever contracted an STD such as Chlamydia or herpes? No Yes _____

What does your family do together? Eat together Activities Recreation _____

Are you living away from home? No Yes _____

Are you satisfied with your job/school? Yes No _____

Do you have any concerns with your sleeping habits? No Yes _____

Are you aware of and try to implement 5-3-2-1-0? Yes No _____

Do you spend more than 2 hrs/day of screen time? No Yes _____

Is there anything you would like to talk about that you don't want to write down? No Yes _____

On a 1 to 5 scale, how do you feel your life is going?

Terrible OK Great

1 2 3 4 5

Do you have any other concerns? _____