CONFIDENTIAL

Young Adult (18 and over) Well Visit

Patient Name_____

Birth Date_____

			Topic Discussed
GENERAL HEALTH			
Have you had any injuries or serious illnesses since last visit?	N	Y	☐
Do you see a dentist regularly?	Y	N	☐
Do you consistently use sunscreen?	Y	N	☐
Has there been a major change in your life recently (such as change in living situation, move, divorce, remarriage, new job, illness or other stressor)?	N	Y	☐
SAFETY			
Do you always wear a seatbelt when you ride in a car?	Y	N	☐
Do you always wear a helmet when rollerblading, skateboarding, or riding a bike, scooter, ATV or snowmobile?	Y	N	☐
Do you use protective gear when playing sports?	Y	N	☐
Do you feel safe at school, work and at home?	Y	N	☐
Do you own a gun or have access to one?	N	Y	☐
Do you have working smoke alarms and carbon monoxide detectors in your home?	Y	N	☐
ALCOHOL/TOBACCO/DRUGS			
Do you smoke cigarettes or chew tobacco?	N	Y	☐
Are you exposed to second hand smoke?	N	Y	☐
Are you worried about any friends or family members and how much they drink or use drugs?	N	Y	☐
During the past year, have you drunk any alcohol?	N	Y	☐
Have you used marijuana or any other drugs to get high?	N	Y	☐
Do you ever fast, vomit or take laxatives or diet pills to control your weight?	N	Y	☐
Do you take any supplements or medicines to build muscle or improve athletic performance?	N	Y	☐
Have you ever ridden in a car driven by someone (including yourself) who was high or had been using alcohol or drugs?	N	Y	☐
Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?	N	Y	☐
Do you ever use alcohol or drugs while you are by yourself alone?	N	Y	☐
Do you ever forget things you did while using alcohol or drugs?	N	Y	☐
Do your family or friends ever tell you that you should cut down on your drinking or drug use?	N	Y	☐
Have you ever gotten into trouble while you were using alcohol or drugs?	N	Y	☐
EMOTIONAL HEALTH			
Have you been in trouble at school, work or with the law?	N	Y	☐
TB (TUBERCULOSIS) RISK			
Have you been exposed to anyone with TB disease or a positive TB skin test?	N	Y	☐
Were you born in or have you traveled to a country with a high risk for TB (Asia, Middle East, Africa, Latin America)?	N	Y	☐
FAMILY HISTORY			
Has your parent or grandparent had a stroke or heart problem before age 55?	N	Y	☐
Does your parent have a high blood cholesterol (over 240) or take cholesterol medication?	N	Y	☐
Is your family medical history unknown?	N	Y	☐
Has there been a change in your family medical history since your last visit?	N	Y	☐
Any other CONCERNS or TOPICS that you want to discuss with your doctor?	N	Y	☐

MD Initials_____

PLEASE CONTINUE ON BACK.

Revised 10/2014

CONFIDENTIAL

Patient Name_____

Sexuality

Are you attracted to? ☐ Opposite Sex ☐ Same Sex ☐ Both ☐Neither

Are you now or have you ever been in an abusive relationship? ☐ No ☐ Yes

Do you have any questions about sex? ☐ No ☐ Yes

Have you ever had sex? ☐ No ☐ Yes

If yes, was your partner(s) (check all that apply): ☐ Opposite Sex ☐Same Sex

Over the past 2 weeks, how often have you been bothered by the following problems? (circle the best answer).

	Not At All	Several Days	Over Half The Days	Nearly Every Day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
				10

Office Use Only Interpretation: ☐ Positive

Total Score: _____ ☐ Negative

Over the past 2 weeks, how often have you been bothered by the following problems? (circle the best answer).

	Not At All	Several Days	Over Half The Days	Nearly Every Day
1. Feeling down, depressed, irritable or hopeless?	0	1	2	3
2. Little interest or pleasure in doing things?	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much?	0	1	2	3
4. Poor appetite, weight loss or overeating?	0	1	2	3
5. Feeling tired, or having little energy?	0	1	2	3
6. Feeling bad about yourself - or feeling that you are a failure, or that you have let yourself or your family down?	0	1	2	3
7. Trouble concentrating on things like school work, reading or watching TV?	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you were moving around a lot more than usual?	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	0	1	2	3
				10

Office Use Only Interpretation: ☐ Positive

Total Score: _____ ☐ Negative

Birth Date_____

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not Difficult ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult

FOLLOW-UP ACTION TAKEN: Check all that apply.

___ Results discussed with patient.

___ Recommend follow-up for evaluation within ___ month(s).

___ Refer to mental health provider.

___ Recommend continued follow-up with current mental health provider.

___ Other (specify):

Reviewed by_____ M.D. Result entered ☐

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____