

## 17-21 Year Well Child Exam Form - MALE

### HEALTH HISTORY

Do you have any questions or concerns about your health that you would like to discuss today?

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What is your health Status? **Good Fair Poor**

Have you been to the emergency room in the past 12 months: **Yes No**

If yes, list why: \_\_\_\_\_

Have you been treated in the hospital in the past 12 months? **Yes No**

If yes, list why: \_\_\_\_\_

Have you ever had any reactions to vaccines / immunizations: **Yes No**

Have you seen a dentist in the last 6 months: **Yes No**

How many times a day do you brush their teeth? \_\_\_\_ How many times a day do you floss? \_\_\_\_

### HOME and FAMILY

Who do you live with: \_\_\_\_\_ How many brothers and sisters do you have? \_\_\_\_

What do you live in? \_\_\_\_\_ How many bedrooms are in your home? \_\_\_\_

Do you share a bedroom: **Yes No** Does anyone in the home smoke? **Yes No**

Is your Father Involved in your life? **Yes No**

How is your relationship with your brothers and/or sisters? **Good Fair Poor N/A, only child**

Is there any history of abuse: **Yes No** Is there any history of neglect? **Yes No**

Does anyone in home use drugs: **Yes No** Is there a history of domestic violence? **Yes No**

Has CPS ever been to your home? **Yes No** If yes, is your CPS case still open? **Yes No**

Has your child ever been in foster care? **Yes No** If yes, how many times? \_\_\_\_

Are you feeling stressed? **Yes No**

Do you have pets in the home: **Yes No** If yes, what type? \_\_\_\_\_

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### SUBSTANCE USE

Circle what describes you:

- **My parents / guardian smoke in the home**
- **My friends smoke**
- **No one I am around smokes**

Have you ever smoked? **Yes No**

If yes, what best describes you: **I've tried it before**      **I use to but I quit**      **I smoke on occasion**  
**I smoke frequently**      **I smoke daily**      How many packs a day? \_\_\_\_\_

Circle what describes you:

- **My parents / guardian and my friends do not drink alcohol**
- **My parents / guardian drink alcohol on occasion**
- **My parents / guardian drink alcohol regularly**
- **My parents / guardian often get drunk**
- **My friends drink alcohol**

Do you drink alcohol? **Yes No** If yes, what do you drink? \_\_\_\_\_ How often? \_\_\_\_\_

Circle what describes you:

- **No one I am around smokes marijuana**
- **My parents / guardian smoke marijuana**
- **My friends smoke marijuana**
- **I know other people that smoke marijuana**

Have you ever smoked marijuana? **Yes No**

If yes, what best describes you: **I've tried it before**      **I smoke it on occasion when my friends have it**  
**I smoke it on occasion when I can buy it**      **I smoke it regularly**      **I smoke it daily**      **I sell it**

Have you ever used other drugs? **Yes No**

If yes, what best describes you: **I've tried it before**      **I use on occasion when my friends have it**  
**I use on occasion when I can buy it**      **I use regularly**      **I use daily**      **I sell it**

What drug do you use? \_\_\_\_\_

### SEXUALITY

Have you ever had sex? **Yes No**

### GENERAL HEALTH

Do you eat from all four food groups including fruit and vegetables? **Yes No**

What type of milk do you drink? **Whole 2% 1% Fat free Lactose free Soy**

What else do you drink and how many glasses a day do you drink? \_\_\_ **Glasses of juice** \_\_\_ **Glasses of water**  
\_\_\_ **glasses of soda** \_\_\_ **glasses of tea** \_\_\_ **cups of coffee** \_\_\_ **cans of energy drinks**

Do you have any problems using the bathroom? (bowel movements or urinating) **Yes No**

How many hours a night do you sleep? \_\_\_\_\_

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Do you exercise: **Yes No** What kind? \_\_\_\_\_

Do you play sports? **Yes No** What kind? \_\_\_\_\_

What clubs/activities are you in at school or after school? \_\_\_\_\_

How many hours a day do you: Watch TV? \_\_\_\_\_ Use the computer? \_\_\_\_\_ Play video games? \_\_\_\_\_

Would you say you have many friends or few? \_\_\_\_\_

Would you say you have high self-esteem or low? \_\_\_\_\_

### SCHOOL

How are your grades? **Excellent good fair poor**

Are your teachers concerned with your school grades? **Yes No** If yes, which classes? \_\_\_\_\_

What are your future career goals? \_\_\_\_\_

### HEARING

Do you have a problem hearing over the telephone? **Yes No**

Do you have trouble following the conversation when 2 or more people are talking at the same time? **Yes No**

Do you have trouble hearing with a noisy background? **Yes No**

Do you find yourself asking people to repeat themselves? **Yes No**

Do you misunderstand what others are saying and respond inappropriately? **Yes No**

### VISION

Do you complain that the blackboard is hard to see? **Yes No**

Have you ever failed a school vision screening test? **Yes No**

Do you hold books close to your eyes to read? **Yes No**

Do you have trouble recognizing faces at a distance? **Yes No**

Do you tend to squint? **Yes No**

### GENERAL SAFETY

Do you wear a seat belt when riding in a car or truck? **Yes No**

Do you have these things in your home:

Smoke detector **Yes No**

Carbon monoxide detector **Yes No**

Fire extinguisher **Yes No**



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Over the last 2 weeks, how often have you been bothered by any of the following problems?  
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself...or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	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 have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns  +  +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off any problems, 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 at all \_\_\_\_\_  
Somewhat difficult \_\_\_\_\_  
Very difficult \_\_\_\_\_  
Extremely difficult \_\_\_\_\_