Comprehensive Screening (adult)

Patient Name: ____ **DOB**: ___/___/___ **Today's Date:** ___/___/___

Which type of visit does your son need today?

Address a specific symptom or issue

- ○ Medication questions/refills (list meds)
- ○ Illness or Physical Symptoms
- ○ Sports Injury
- ○ Social, Emotional, Mood Concerns
- ○ Sexuality
- ○ Nutrition, Body Image
- ○ Risk Behaviors, Safety
- ○ Other: ______________________________________

Please Explain

____

____

____

____

____

____

OR

Annual Exam (well-check) which includes

- School / camp / college physical forms
- Annual disability paperwork
- Immunizations
- Wellness screening labs
- Brief update of chronic, stable conditions
- Refill of medications (no changes or problems)
- General health education

If the physician conducts **BOTH** types of services, additional fees may be charged or a separate appointment may be needed.

- **Additional FEES**: Please understand that most insurance companies do not pay for care of problems and preventive care on the same day. The patient would be responsible for the additional fees.
- **Additional TIME**: There may not be enough time to thoroughly address everything. Another appointment may be needed to fully address all the issues.

Your Name: ______________________________ **Relationship to Patient:** ❐ Mother ❐ Father ❐ Other: _______________

Signature: ____ **Date**: _____/_____/_____

Please give to the front desk staff:

❐ Immunization Records ❐ Forms (e.g. camp,sports) that require medical provider signature

If new patient, who referred you to Young Men's Health and Wellness?

Referred by: ______________________________________ ❐ physician ❐ therapist ❐ Other: _____________________

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Overall, how is he doing…		Doing Well / No concerns	Minor Concerns	Major/ Significant Concerns	Please describe
Physical Health Symptoms		☐	☐	☐	
School/ Work	general level of motivation, work ethic, attendance, performance	☐	☐	☐	
Relationships outside the home	friends, teachers, co-worker	☐	☐	☐	
Family Relationships	parents, siblings and others at home	☐	☐	☐	
Self-Care	basic hygiene, bathing, sleeping	☐	☐	☐	
Nutrition/ Body Image	eating patterns, self-image	☐	☐	☐	
Sexual Health	Puberty, sexual development, sexual identity, birth control, sexually transmitted diseases,	☐	☐	☐	
Mood/ Attitude	general level of happiness, optimism, work ethic, hopefulness	☐	☐	☐	
Risk Behavior	inappropriate internet and/or cell phone use; alcohol / marijuana / drug use; sneaking out; inappropriate sexual behaviors/relationships	☐	☐	☐	
Safety Concerns	self-harm, suicidal thoughts	☐	☐	☐	

About your son…

Your relationship to Patient: ❐ Mother ❐ Father ❐ Other: ______________________

What about him makes you proud?

____

____

____

____

What seems to be the greatest challenge for him? ____

____

____

____

__________% (out of 100) Overall Functional Assessment: Compared to what you think would be "normal, healthy life functioning", how do YOU THINK you/your child is doing (no right or wrong answer, just your best guess)?

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Current Medications				
Medication Name	**Dose**	**Prescribing Physician**	**Need Refill?**	**Quantity Needed**
			❐ Yes	❐ 30 day ❐ 90 day
			❐ Yes	❐ 30 day ❐ 90 day
			❐ Yes	❐ 30 day ❐ 90 day
			❐ Yes	❐ 30 day ❐ 90 day

Medical History

Prenatal / Birth History: ❐ Normal ❐ Issues/Concerns: ____

Overall Growth and Development: ❐ Normal ❐ Issues/Concerns: ____

Medication Allergies (and reaction)____

Food/Other Allergies *(*and reaction*)*____

Any surgeries (physician, approximate age or date) ____

____

Any Hospitalizations (clinic/hospital/treatment center, approximate age or date) _________________________________

____

Most recent Annual (Wellness) exam: Approximate Age or Date: ________ Physician: _____________

Most recent lab tests

❐ Cholesterol Approximate Age or Date: ________________ Results: ❐ Normal ❐ Abnormal

❐ Other Approximate Age or Date: ________________ Results: ❐ Normal ❐ Abnormal

Patient Social History

School: _________________________ Current Grade (e.g. 7th): _______ School Year (e.g 2015-2016) ___________

Activities, Clubs, Hobbies: ____

Employment: ____

	Who does patient live with most of the time?	Occupation
Mother	❐	
Father	❐	
Step-Mother	❐	
Step-Father	❐	
Brother(s)	❐	Ages:
Sister(s)	❐	Ages:

Parents are:

□ Married
□ Separated
□ Divorced (□ Mom remarried □ Dad remarried)
□ Widowed

If patient lives in more than one home, what are the custodial arrangements?

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Patient Medical Issues (Past or Present) Check this box ❒ if none apply

	Age of Diagnosis	Specialist	Current Status (Please explain)
Allergy/Asthma/Immunology ❒ asthma ❒ seasonal allergies ❒ food allergies ❒ frequent infections ❒ immune deficiency ❒ other:			❒ Resolved ❒ Stable ❒ Problematic
Dermatology ❒ acne ❒ eczema ❒ birthmarks ❒ other:			❒ Resolved ❒ Stable ❒ Problematic
Gastroenterology ❒ irritable bowel syndrome ❒ reflux,GERD, heartburn ❒ chronic constipation ❒ Crohn's or ulcerative colitis ❒ celiac disease ❒ gall bladder / liver disease ❒ blood in stools ❒ other:			❒ Resolved ❒ Stable ❒ Problematic
Endocrine ❒ thyroid disorder ❒ diabetes type 1 ❒ diabetes type 2 ❒ PCOS ❒ other:			❒ Resolved ❒ Stable ❒ Problematic
Orthopedic ❒ broken bones ❒ arthritis ❒ scoliosis ❒ joint probelms ❒ other:			❒ Resolved ❒ Stable ❒ Problematic
Infectious Disease ❒ chicken pox ❒ mononucleosis ❒ recurrent pneumonia ❒ recurrent sinus infections ❒ MRSA ❒ other:			❒ Resolved ❒ Stable ❒ Problematic

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Patient Medical Issues **(Past or Present)** Check this box ❐ if none apply

	Age of Diagnosis	Specialist	Current Status (Please explain)
Cardiovascular/Hematology ❐ anemia (explain type) ❐ heart murmur ❐ abnormal heart valve(s) ❐ fainting or dizziness with exercise ❐ bleeding disorder ❐ blood clot / clotting disorder ❐ high cholesterol ❐ high blood pressure ❐ other:			❐ Resolved ❐ Stable ❐ Problematic
Neurology ❐ migraines ❐ tics ❐ seizures ❐ other			❐ Resolved ❐ Stable ❐ Problematic
Urology ❐ recurrent urinary tract infections ❐ kidney problems ❐ testicular pain ❐ penile discharge ❐ sexually transmitted infection ❐ other:			❐ Resolved ❐ Stable ❐ Problematic
Neurodevelopmental ❐ birth complications ❐ developmental delay ❐ genetic disorder ❐ learning disorder ❐ autism ❐ Asperger's ❐ ADD/ADHD ❐ speech or language delay ❐ other:			❐ Resolved ❐ Stable ❐ Problematic
Psychological ❐ depression ❐ anxiety ❐ eating disorder ❐ alcohol use ❐ drug use ❐ tobacco use ❐ suicide attempt ❐ cutting / self-harm behavior ❐ other:		**Psychiatrist:** ________ ____________________ **Therapist:** __________ ____________________ **Dietitian:** ___________ ____________________	❐ Resolved ❐ Stable ❐ Problematic

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Family MEDICAL History or Check this box ❒ if none apply					
	Mother	**Father**	**Siblings**	**Grandparents**	**Other**
Asthma					
Bleeding or clotting disorders					
Blood disorders or sickle cell anemia					
Heart attack/stroke					
High blood pressure					
High cholesterol					
Kidney disease					
PCOS					
Migraine headaches					
Obesity					
Diabetes					
Thyroid disease					
Crohns/ulcerative colitis					
Rheumatoid arthritis					
Cancer (type) (________________)					
Other					

Family MENTAL HEALTH History or Check this box ❒ if none apply					
	Mother	**Father**	**Siblings**	**Grandparents**	**Other**
Depression					
Anxiety					
OCD					
Bipolar					
Schizophrenia					
Learning disability					
ADD/ADHD					
Alcohol/drug abuse					
Eating disorder					
Suicide					
Other					

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