



Bright Futures Previsit Questionnaire

18 to 21 Year Visits

For us to provide you with the best possible health care, we would like to get to know you better and know how things are going for you. Our discussions with you are private. We hope you will feel free to talk openly with us about yourself and your health. Information is not shared with other people without your permission unless we are concerned that someone is in danger. Thank you for your time.

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today?

What changes or challenges have there been at home since your last visit?

Do you have any special health care needs? No Yes, describe:

Do you live with anyone who uses tobacco or spend time in any place where people smoke? No Yes, describe:

How many hours per day do you watch TV, play video games, and use the computer (not for schoolwork)?

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

Your Growing and Changing Body	<input type="checkbox"/> How your body is changing <input type="checkbox"/> Teeth <input type="checkbox"/> Appearance or body image <input type="checkbox"/> How you feel about yourself <input type="checkbox"/> Healthy eating <input type="checkbox"/> Good ways to be active <input type="checkbox"/> Protecting your ears from loud noise
School and Friends	<input type="checkbox"/> How you are doing in school <input type="checkbox"/> Organizing your time to get things done <input type="checkbox"/> Your job <input type="checkbox"/> Your future plans <input type="checkbox"/> Your friends <input type="checkbox"/> Girlfriend or boyfriend <input type="checkbox"/> Your relationship with your family
How You Are Feeling	<input type="checkbox"/> Dealing with stress <input type="checkbox"/> Keeping under control <input type="checkbox"/> Making decisions on your own <input type="checkbox"/> Sexuality <input type="checkbox"/> Depression <input type="checkbox"/> Feeling anxious <input type="checkbox"/> Feeling irritable <input type="checkbox"/> Feeling sad
Healthy Behavior Choices	<input type="checkbox"/> Pregnancy <input type="checkbox"/> Sexually transmitted infections (STIs) <input type="checkbox"/> Smoking cigarettes <input type="checkbox"/> Drinking alcohol <input type="checkbox"/> Using drugs <input type="checkbox"/> How to avoid risky situations <input type="checkbox"/> How to support friends who don't use alcohol and drugs <input type="checkbox"/> How to follow through with decisions you have made about sex and drugs
Violence and Injuries	<input type="checkbox"/> Avoiding driving distractions <input type="checkbox"/> Drinking and driving <input type="checkbox"/> Gun safety <input type="checkbox"/> Dating violence or abuse

Questions

Vision	Do you complain that the blackboard has become difficult to see?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have you ever failed a school vision screening test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you hold books close to your eyes to read?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you have trouble recognizing faces at a distance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you tend to squint?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Hearing	Do you have a problem hearing over the telephone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you have trouble following the conversation when 2 or more people are talking at the same time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you have trouble hearing with a noisy background?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you find yourself asking people to repeat themselves?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you misunderstand what others are saying and respond inappropriately?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Tuberculosis	Were you born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have you traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have you ever been incarcerated (in jail)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Are you infected with HIV?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Dyslipidemia	Do you have parents or grandparents who have had a stroke or heart problem before age 55?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you have a parent with an elevated blood cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you smoke cigarettes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Anemia	Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unsure
	Have you ever been diagnosed with iron deficiency anemia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure



Alcohol or Drug Use	Have you ever had an alcoholic drink?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have you ever used marijuana or any other drug to get high?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
STIs	Do you now use or have you ever used injectable drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

For Females Only

Anemia	Do you have excessive menstrual bleeding or other blood loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your period last more than 5 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
STIs	Have you ever had sex (including intercourse or oral sex)? (If no, skip to Growing and Developing)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have any of your past or current sex partners been infected with HIV, bisexual, or injection drug users?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have you ever been treated for a sexually transmitted infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Are you having unprotected sex with multiple partners?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Cervical Dysplasia	Do you trade sex for money or drugs or have sex partners who do?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Was your first time having sexual intercourse more than 3 years ago?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Pregnancy	Have you been sexually active without using birth control?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have you been sexually active and had a late or missed period within the last 2 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

For Males Only

STIs	Have you ever had sex (including intercourse or oral sex)? (If no, skip to Growing and Developing)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have you ever been treated for a sexually transmitted infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Are you having unprotected sex with multiple partners?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have you ever had sex with other men?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you trade sex for money or drugs or have sex partners who do?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have any of your past or current sex partners been infected with HIV, bisexual, or injection drug users?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

Growing and Developing

Check off all the items that you feel are true for you.

- I engage in behavior that supports a healthy lifestyle, such as eating healthy foods, being active, and keeping myself safe.
- I feel I have at least one responsible adult in my life who cares about me and who I can go to if I need help.
- I feel like I have at least one friend or a group of friends with whom I am comfortable.
- I help others on my own or by working with a group in school, a faith-based organization, or the community.
- I am able to bounce back from life's disappointments.
- I have a sense of hopefulness and self-confidence.
- I have become more independent and made more of my own decisions as I have become older.
- I feel that I am particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting. Describe:



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ACCOMPANIED BY/INFORMANT	PREFERRED LANGUAGE	DATE/TIME	Name	
DRUG ALLERGIES	CURRENT MEDICATIONS		ID NUMBER	
WEIGHT (%)	HEIGHT (%)	BMI (%)	BLOOD PRESSURE	BIRTH DATE
				AGE

Visit with: Teen alone Parent(s) alone Mother Father Teen with parents Other _____

History

<input type="checkbox"/> Previsit Questionnaire reviewed	<input type="checkbox"/> Teen has special health care needs
<input type="checkbox"/> Teen has a dental home	

Concerns and questions None Addressed (see other side)

Follow-up on previous concerns None Addressed (see other side)

Interval history None Addressed (see other side)

Menarche: Age _____ Regularity _____

Menstrual problems _____

Medication Record reviewed and updated

Physical Examination

= NL

Bright Futures Priority

SKIN

BACK/SPINE

BREASTS

GENITALIA

SEXUAL MATURITY RATING _____

Additional Systems

GENERAL APPEARANCE TEETH

HEAD LUNGS

EYES HEART

EARS GI/ABDOMEN

NOSE EXTREMITIES

MOUTH AND THROAT NEUROLOGIC

NECK MUSCULO-SKELETAL

Abnormal findings and comments _____

Social/Family History

See Initial History Questionnaire. No interval change

Changes since last visit _____

Teen lives with _____

Relationship with parents/siblings _____

Assessment

Well teen

Risk Assessment

If not reviewed in Supplemental Questionnaire (Use other side if risks identified.)

HOME

Eats meals with family Yes No

Has family member/adult to turn to for help Yes No

Is permitted and is able to make independent decisions Yes No

EDUCATION

Grade _____

Performance NL _____

Behavior/Attention NL _____

Homework NL _____

EATING

Eats regular meals including adequate fruits and vegetables Yes No

Drinks non-sweetened liquids Yes No

Calcium source Yes No

Has concerns about body or appearance Yes No

ACTIVITIES

Has friends Yes No

At least 1 hour of physical activity/day Yes No

Screen time (except for homework) less than 2 hours/day Yes No

Has interests/participates in community activities/volunteers Yes No

DRUGS (Substance use/abuse)

Uses tobacco/alcohol/drugs Yes No

SAFETY

Home is free of violence Yes No

Uses safety belts/safety equipment Yes No

Impaired/Distracted driving Yes No

Has relationships free of violence Yes No

SEX

Has had oral sex Yes No

Has had sexual intercourse (vaginal, anal) Yes No

SUICIDALITY/MENTAL HEALTH

Has ways to cope with stress Yes No

Displays self-confidence Yes No

Has problems with sleep Yes No

Gets depressed, anxious, or irritable/has mood swings Yes No

Has thought about hurting self or considered suicide Yes No

Anticipatory Guidance

Discussed and/or handout given

PHYSICAL GROWTH AND DEVELOPMENT

- Balanced diet
- Physical activity
- Limit TV
- Protect hearing
- Brush/Floss teeth
- Regular dentist visits

SOCIAL AND ACADEMIC COMPETENCE

- Age-appropriate limits
- Friends/relationships
- Family time
- Community involvement
- Encourage reading/school
- Rules/Expectations
- Planning for after high school
- Decision-making
- Mood changes
- Sexuality/Puberty

RISK REDUCTION

- Tobacco, alcohol, drugs
- Prescription drugs
- Sex

VIOLENCE AND INJURY PREVENTION

- Seat belts
- Guns
- Conflict resolution
- Driving restriction
- Sports/Recreation safety

Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results: Vision Cholesterol (18–21 years)

Referral to _____

Follow-up/Next visit _____

See other side

Print Name	Signature
PROVIDER 1	
PROVIDER 2	



Psychosocial Risks

Confidential (To be completed confidentially for teens with identified risk)

Home

Relationship with parents/guardians _____

Violence in home _____

Teen's concerns _____

Autonomy _____

Counseling/Recommendations _____

Education

Teen's concerns _____

Social interactions _____

Conflicts _____

Counseling/Recommendations _____

Eating

Usual diet _____

Attempts to lose weight by dieting, laxatives, or self-induced vomiting _____

Regular meals (includes breakfast, limits fast food) _____

Counseling/Recommendations _____

Activities

Clubs/Extracurricular _____

Music/Art _____

Sports _____

Religious/Community _____

TV/Electronics _____ hours/day

Gangs _____

Counseling/Recommendations _____

CRAFFT used with permission from Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Arch Pediatr Adolesc Med.* 2002;156:607-614

HEEADSSS used with permission from Goldenring JM, Rosen DS. Getting into adolescent heads: an essential update. *Contemp Pediatr.* 2004;21:64-90

This American Academy of Pediatrics Visit Documentation Form is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd Edition.

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Drugs (Substance Use/Abuse)

Tobacco use _____
Alcohol _____
Drugs (street/prescription) _____
Steroids _____
CRAFFT (+2 indicates need for follow-up)
C – Have you ever ridden in a CAR driven by someone (including yourself) who was “high” or had been using alcohol or drugs? Yes No
R – Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in? Yes No
A – Do you ever use alcohol or drugs while you are by yourself, ALONE? Yes No
F – Do you ever FORGET things you did while using alcohol or drugs? Yes No
F – Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use? Yes No
T – Have you gotten into TROUBLE while you were using alcohol or drugs? Yes No
Counseling/Recommendations _____

Safety

Impaired/Distracted driving _____
Sports/recreation safety _____
Guns _____
Peer violence _____
Dating violence _____
Counseling/Recommendations _____

Sex

Oral sex Yes No
Has had sexual intercourse (vaginal, anal) Yes No
Age of onset of sexual activity _____
Number of partners _____ Gender of partners Male Female
Sexual orientation _____
Condom use _____ Contraception _____
Previous pregnancy No Yes _____
Previous STI No Yes _____
Laboratory/Screening results
 Pregnancy test Pap smear
 Chlamydia/Gonorrhea, source _____ Syphilis HIV
STI screening laboratory results (specify) _____

Counseling/Recommendations _____

Suicidality/Mental Health

Depression No Yes—when? _____
Anxiety No Yes—when? _____
Suicide ideation No Yes—when? _____
Suicide attempts No Yes—when? _____
History of psychologic counseling No Yes—when? _____
Other mental health diagnosis _____
Counseling/Recommendations _____

Confidentiality discussed With teen With parent(s)



Bright Futures Patient Handout

18 to 21 Year Visits

Your Daily Life

- Visit the dentist at least twice a year.
- Protect your hearing at work, home, and concerts.
- Eat a variety of healthy foods.
- Eat breakfast every morning.
- Drink plenty of water.
- Make sure to get enough calcium.
 - Have 3 or more servings of low-fat (1%) or fat-free milk and other low-fat dairy products each day.
- Aim for 1 hour of vigorous physical activity.
- Be proud of yourself when you do something well.

PHYSICAL GROWTH AND DEVELOPMENT

Healthy Behavior Choices

- Support friends who choose not to use drugs, alcohol, tobacco, steroids, or diet pills.
- If you use drugs or alcohol, you can talk to us about it. We can help you with quitting or cutting down on your use.
- Make healthy decisions about your sexual behavior.
- If you are sexually active, always practice safe sex. Always use a condom to prevent STIs.
- All sexual activity should be something you want. No one should ever force or try to convince you.
- Find safe activities at school and in the community.

RISK REDUCTION

Violence and Injuries

- Do not drink and drive or ride in a vehicle with someone who has been using drugs or alcohol.
 - If you feel unsafe driving or riding with someone, call someone you trust to drive you.
- Always wear a seat belt in the car.
- Know the rules for safe driving.
- Never allow physical harm of yourself or others at home or school.
- Always deal with conflict using nonviolence.
- Remember that healthy dating relationships are built on respect and that saying “no” is OK.
- Fighting and carrying weapons can be dangerous.

PHYSICAL GROWTH AND DEVELOPMENT

Your Feelings

- Figure out healthy ways to deal with stress.
- Try your best to solve problems and make decisions on your own.
- Most people have daily ups and downs. But if you are feeling sad, depressed, nervous, irritable, hopeless, or angry, talk with me or another health professional.
- We understand sexuality is an important part of your development. If you have any questions or concerns, we are here for you.

EMOTIONAL WELL-BEING

School and Friends

- Take responsibility for being organized enough to succeed in work or school.
- Find new activities you enjoy.
- Consider volunteering and helping others in the community on an issue that interests or concerns you.
- Form healthy friendships and find fun, safe things to do with friends.
- As you get older, making and keeping friends is important. You may find that you drift away from some of your old friends—that’s normal.
- Evaluate your friendships and keep those that are healthy.
- It is still important to stay connected with your family.

SOCIAL AND ACADEMIC COMPETENCE



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