Bright Futures Adolescent Supplemental Questionnaire—Older Child/Younger Adolescent 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.

Your Name _____ Today's Date _____

Your Age _____ Your Sex (circle one): M F Your Grade (in school) _____

Your Growing and Changing Body: Physical Growth and Development

1.	Do you live in your parents' home?	Yes	Sometimes	No
2.	Do you receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, or other healer)?	No		Yes
3.	Do you brush your teeth twice a day?	Yes		No
4.	Do you floss once a day?	Yes		No
5.	Have you seen a dentist in the past year?	Yes		No
6.	Do you eat 5 or more helpings of fruits and vegetables each day?	Yes		No
7.	Do you drink milk and eat yogurt, cheese, or other calcium-rich foods (such as dark-green leafy vegetables, or calcium-fortified orange juice or cereal) at least 3 times each day?	Yes		No
8.	Do you eat more than 1 fast food meal per week?	No	Sometimes	Yes
9.	Do you participate in any physical activities, such as walking, skateboarding, dancing, swimming, or playing basketball, for a total of 1 hour each day?	Yes		No
10.	Do you drink more than 1 soda or juice drink each day?	No		Yes
11.	Do you watch TV, play video games, or spend time on the computer for more than 2 hours per day (not including computer time for homework)?	No		Yes
12.	Do you have any concerns or questions about the size or shape of your body, or physical appearance?	No		Yes
13.	Do you have a problem with your weight (such as underweight, overweight, anorexia, or bulimia)?	No		Yes
14.	Are you on a diet to lose weight?	No		Yes
15.	Do you eat meals together as a family?	Yes		No
16.	Have you talked about body changes and puberty with your parents?	Yes		No
17.	Do you have a TV in your bedroom?	No		Yes
18.	Have you talked to your parents about waiting to have sex?	Yes		No
19.	For females: Have you gotten your period?	Yes		No
20.	If yes, are you having any problems with or do you have any questions about your period?	No	Sometimes	Yes

School and Friends: Social and Academic Competence

21.	Do you go to school?	Yes		No
22.	Are you having any problems in school? Circle all that apply: grades worse than last year failing grade homework suspension this year fighting missing school other _____	No	Sometimes	Yes
23.	Is doing well in school important to you?	Yes		No
24.	Do your parents know your friends and their families?	Yes		No
25.	Do you try to see things from another person's point of view?	Yes		No
26.	Do you try to think through solutions by yourself?	Yes		No

Violence and Injuries: Violence and Injury Prevention

27.	Do you always wear a seat belt when riding in a car, truck, or van?	Yes	Sometimes	No
28.	Do you ever carry a gun (even to protect yourself) or have access to a gun at home or in places where you spend time?	No	Sometimes	Yes
29.	Do you wear a helmet when you in-line skate, skateboard, bicycle, ski, or snowboard?	Yes	Sometimes	No
30.	Is there someone at home, school, or anywhere else who has made you feel afraid, threatened you, or hurt you?	No		Yes
31.	Do you have a person you can call for a ride if you're feeling unsafe with someone?	Yes		No

How You Are Feeling: Emotional Well-being

32.	Even with usual ups and downs, do you feel you enjoy life?	Yes		No
33.	Do your parents praise you when you do something good or learn something new?	Yes		No
34.	Do you spend time talking with your parents every day?	Yes		No
35.	Do you clearly discuss with your parents their rules and how you should act?	Yes		No
36.	Do you worry a lot or feel overly stressed out?	No	Sometimes	Yes
37.	When you are angry, do you do violent things?	No		Yes
38.	Do you continue to remember or think about an unpleasant experience that happened in the past?	No		Yes

continued on page 3

Feeling Happy: Emotional Well-being *continued from page 2*

39.	Do you do things as a family?	**Yes**		**No**
40.	During the past few weeks have you often felt sad or down, had difficulty sleeping, or frequently felt irritable or as though you have nothing to look forward to?	**No**		**Yes**
41.	Do you talk with your parents about relationships and sex?	**Yes**		**No**
42.	Do you talk with your parents about alcohol and drugs?	**Yes**		**No**
43.	Have you ever seriously thought about killing yourself, made a plan, or tried to kill yourself?	**No**		**Yes**

Healthy Behavior Choices: Risk Reduction

44.	Does anyone you live with smoke cigarettes or cigars or chew tobacco?	**No**	**Sometimes**	**Yes**

Bright Futures Parent Supplemental Questionnaire Older Child/Early Adolescent Visits

Your Child's Name _____ Today's Date _____

Your Child's Age _____ Your Child's Sex (circle one): M F Your Child's Grade (in school) _____

Your Growing and Changing Child: Physical Growth and Development

1.	Does your child live in your home?	**Yes**	**Sometimes**	**No**
2.	Does your child receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, or other healer)?	**No**		**Yes**
3.	Does your child brush his teeth twice a day?	**Yes**		**No**
4.	Does your child floss once a day?	**Yes**		**No**
5.	Has your child seen a dentist in the past year?	**Yes**		**No**
6.	Does your child eat 5 or more helpings of fruits and vegetables each day?	**Yes**		**No**
7.	Does your child drink milk and eat yogurt, cheese, or other calcium-rich foods (such as dark-green leafy vegetables, or calcium-fortified orange juice or cereal) at least 3 times each day?	**Yes**		**No**
8.	Does your child eat more than 1 fast food meal per week?	**No**	**Sometimes**	**Yes**
9.	Does your child do any physical activities, such as walking, skateboarding, dancing, swimming, or playing basketball, for a total of 1 hour each day?	**Yes**		**No**
10.	Does your child drink more than 1 soda or juice drink each day?	**No**		**Yes**
11.	Does your child watch TV, play video games, or spend time on the computer for more than 2 hours per day (not including computer time for homework)?	**No**		**Yes**
12.	Does your child have a problem with weight (such as underweight, overweight, anorexia, or bulimia)?	**No**		**Yes**
13.	Do you eat meals together as a family?	**Yes**		**No**
14.	Have you and your child discussed the physical and emotional changes that happen during puberty?	**Yes**		**No**
15.	Does your child have a TV in his bedroom?	**No**		**Yes**
16.	Have you talked to your child about waiting to have sex?	**Yes**		**No**
17.	For your daughter: Have she gotten her period?	**Yes**		**No**
18.	If yes, is she having any problems with or does she have any questions about her period?	**No**	**Sometimes**	**Yes**

School and Friends: Social and Academic Competence

19.	Does your child go to school?	Yes		No
20.	Is your child having any problems in school? Circle all that apply: grades worse than last year failing grades homework suspension this year fighting missing school other_____	No	Sometimes	Yes
21.	Is doing well in school important to you and your child?	Yes		No
22.	Do you know your child's friends and their families?	Yes		No
23.	Do you help your child see things from another person's point of view?	Yes		No
24.	Do you encourage your child to think through solutions rather than giving her the answers?	Yes		No

Violence and Injuries: Violence and Injury Prevention

25.	Does your child always wear a seat belt when riding in a car, truck, or van?	Yes	Sometimes	No
26.	Does your child have access to a gun at home or in places where she spends time?	No	Sometimes	Yes
27.	Does your child wear a helmet when he in-line skates, skateboards, bicycles, skis, or snowboards?	Yes	Sometimes	No
28.	Has your child had someone at home, school, or anywhere else who made her feel afraid, threatened her, or hurt her?	No		Yes
29.	Does your child wear protective gear when playing team sports?	Yes		No

Feeling Happy: Emotional Well-being

30.	Even with usual ups and downs, do you feel your child enjoys life?	Yes		No
31.	Do you praise your child when he does something good or learns something new?	Yes		No
32.	Do you spend time talking with your child every day?	Yes		No
33.	Do you clearly discuss with your child rules and family rules?	Yes		No
34.	Does your child worry a lot or feel overly stressed out?	No	Sometimes	Yes
35.	When your child is angry, does he do violent things?	No		Yes
36.	Does your child continue to remember, think, or talk about an unpleasant experience that happend in the past?	No		Yes

continued on page 3

Feeling Happy: Emotional Well-being *continued from page 2*

37.	During the past few weeks has your child often felt sad or down, had difficulty sleeping, or frequently felt irritable or as though he has nothing to look forward to?	**No**		**Yes**
38.	Do you talk with your child about relationships and sex?	**Yes**		**No**
39.	Do you talk with your child about alcohol and drugs?	**Yes**		**No**
40.	Has your child ever seriously thought about killing himself, made a plan, or tried to kill himself?	**No**		**Yes**

Healthy Behavior Choices: Risk Reduction

41.	Does anyone you live with smoke cigarettes or cigars or chew tobacco?	**No**	**Sometimes**	**Yes**

Bright Futures Medical Screening Questionnaire
Older Child/Younger Adolescent Visits

For Parents

Please answer the following questions by circling Y, N, or Unsure.

Does your child complain that the blackboard has become difficult to see?	Y	N	Unsure
Has your child ever failed a school vision screening test?	Y	N	Unsure
Does your child hold books close to read?	Y	N	Unsure
Does your child have trouble recognizing faces at a distance?	Y	N	Unsure
Does your child tend to squint?	Y	N	Unsure
Does your child have a problem hearing over the telephone?	Y	N	Unsure
Does your child have trouble following the conversation when 2 or more people are talking at the same time?	Y	N	Unsure
Does your child have trouble hearing with a noisy background?	Y	N	Unsure
Does your child ask people to repeat themselves?	Y	N	Unsure
Does your child misunderstand what others are saying and respond inappropriately?	Y	N	Unsure
Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?	Y	N	Unsure
Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	Y	N	Unsure
Has a family member or contact had tuberculosis or a positive tuberculin skin test?	Y	N	Unsure
Is your child infected with HIV?	Y	N	Unsure
Does your child have parents or grandparents who have had a stroke or heart problem before age 55?	Y	N	Unsure
Does your child have a parent with an elevated blood cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?	Y	N	Unsure
Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	N	Y	Unsure
Has your child ever been diagnosed with iron deficiency anemia?	Y	N	Unsure

FOR FEMALES ONLY

Does your child have excessive menstrual bleeding or other blood loss?	Y	N	Unsure
Does your child's period last more than 5 days?	Y	N	Unsure

For Patients

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.

Please answer the following questions by circling Y, N, or Unsure.

Do you smoke cigarettes?	Y	N	Unsure
Have you ever had an alcoholic drink?	Y	N	Unsure
Have you ever used marijuana or any other drug to get high?	Y	N	Unsure
Have you ever been diagnosed with iron deficiency anemia?	Y	N	Unsure
Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	N	Y	Unsure
FOR FEMALES ONLY			
Does your period last more than 5 days?	Y	N	Unsure
Do you have excessive menstrual bleeding or other blood loss?	Y	N	Unsure