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

Questions

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

Alcohol or Drug Use	Have you ever had an alcoholic drink?	☐ Yes	☐ No	☐ Unsure
	Have you ever used marijuana or any other drug to get high?	☐ Yes	☐ No	☐ Unsure
STIs	Do you now use or have you ever used injectable drugs?	☐ Yes	☐ No	☐ Unsure
For Females Only				
Anemia	Do you have excessive menstrual bleeding or other blood loss?	☐ Yes	☐ No	☐ Unsure
	Does your period last more than 5 days?	☐ Yes	☐ No	☐ Unsure
STIs	Have you ever had sex (including intercourse or oral sex)? **(If no, skip to Growing and Developing)**	☐ Yes	☐ No	☐ Unsure
	Have any of your past or current sex partners been infected with HIV, bisexual, or injection drug users?	☐ Yes	☐ No	☐ Unsure
	Have you ever been treated for a sexually transmitted infection?	☐ Yes	☐ No	☐ Unsure
	Are you having unprotected sex with multiple partners?	☐ Yes	☐ No	☐ Unsure
	Do you trade sex for money or drugs or have sex partners who do?	☐ Yes	☐ No	☐ Unsure
Cervical Dysplasia	Was your **first** time having sexual intercourse more than 3 years ago?	☐ Yes	☐ No	☐ Unsure
Pregnancy	Have you been sexually active without using birth control?	☐ Yes	☐ No	☐ Unsure
	Have you been sexually active and had a late or missed period within the last 2 months?	☐ Yes	☐ No	☐ Unsure
For Males Only				
STIs	Have you ever had sex (including intercourse or oral sex)? **(If no, skip to Growing and Developing)**	☐ Yes	☐ No	☐ Unsure
	Have you ever been treated for a sexually transmitted infection?	☐ Yes	☐ No	☐ Unsure
	Are you having unprotected sex with multiple partners?	☐ Yes	☐ No	☐ Unsure
	Have you ever had sex with other men?	☐ Yes	☐ No	☐ Unsure
	Do you trade sex for money or drugs or have sex partners who do?	☐ Yes	☐ No	☐ Unsure
	Have any of your past or current sex partners been infected with HIV, bisexual, or injection drug users?	☐ Yes	☐ No	☐ 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:

_____

_____

TO BE FILLED OUT BY PROVIDER

ACCOMPANIED BY/INFORMANT	PREFERRED LANGUAGE	DATE/TIME	Name

DRUG ALLERGIES	CURRENT MEDICATIONS	ID NUMBER

WEIGHT (%)	HEIGHT (%)	BMI (%)	BLOOD PRESSURE	BIRTH DATE	AGE
					☐M ☐F

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

History

☐ Previsit Questionnaire reviewed
☐ Teen has a dental home
☐ Teen has special health care needs

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

Social/Family History

See Initial History Questionnaire. ☐ No interval change

Changes since last visit _____

Teen lives with _____

Relationship with parents/siblings _____

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

Physical Examination

☑= NL

Bright Futures Priority
- ☐ **SKIN**
- ☐ **BACK/SPINE**
- ☐ **BREASTS**
- ☐ **GENITALIA**
- **SEXUAL MATURITY RATING** _____

Additional Systems
- ☐ GENERAL APPEARANCE
- ☐ HEAD
- ☐ EYES
- ☐ EARS
- ☐ NOSE
- ☐ MOUTH AND THROAT
- ☐ NECK
- ☐ TEETH
- ☐ LUNGS
- ☐ HEART
- ☐ GI/ABDOMEN
- ☐ EXTREMITIES
- ☐ NEUROLOGIC
- ☐ MUSCULO-SKELETAL

Abnormal findings and comments _____

Assessment

☐ Well teen

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

☐ EMOTIONAL WELL-BEING
- Dealing with stress
- 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 _____

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)

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.

Bright Futures Patient Handout
18 to 21 Year Visits

PHYSICAL GROWTH AND DEVELOPMENT

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.

RISK REDUCTION

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.

VIOLENCE AND INJURY PREVENTION

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.

EMOTIONAL WELL-BEING

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.

SOCIAL AND ACADEMIC COMPETENCE

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.

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

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DEDICATED TO THE HEALTH OF ALL CHILDREN™