CLEAR FORM

**PATIENT NAME:** _____ **DATE:** _____

Please print.

American Academy of Pediatrics

# BRIGHT FUTURES PREVISIT QUESTIONNAIRE
# 18 THROUGH 21 YEAR VISITS

To give you the best possible health care, we would like to know how things are going. 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. **Depression screening and Tobacco, Alcohol, or Drug Use assessment are also part of this visit.** 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? ○ **No** ○ **Yes,** describe:

## TELL US ABOUT YOURSELF.

What are you most proud of about yourself?

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

Have there been major changes lately in your family's life? ○ **No** ○ **Yes,** describe:

Have any of your relatives developed new medical problems since your last visit? ○ **No** ○ **Yes** ○ **Unsure** If yes or unsure, please describe:

Do you live with anyone who smokes or spend time in places where people smoke or use e-cigarettes? ○ **No** ○ **Yes** ○ **Unsure**

## GROWING AND DEVELOPING

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

- ☐ I do things that help me have a healthy lifestyle, such as eating healthy foods, being physically active, and keeping myself safe.
- ☐ I have at least one adult in my life who I know I can go to if I need help.
- ☐ I have a friend or a group of friends that I feel comfortable to be around.
- ☐ I help others.
- ☐ I am able to bounce back when life doesn't go my way.
- ☐ I feel hopeful and confident.
- ☐ I am becoming more independent and I make more of my own decisions.

**PATIENT NAME:** _____ **DATE:** _____

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# 18 THROUGH 21 YEAR VISITS

## RISK ASSESSMENT

| | | | | |
|---|---|---|---|---|
| **Anemia** | Does your diet include iron-rich foods, such as meat, iron-fortified cereals, or beans? | O Yes | O No | O Unsure |
| | Do you eat a vegetarian diet (do not eat red meat, chicken, fish, or seafood)? | O No | O Yes | O Unsure |
| | If you are a vegetarian (do not eat red meat, chicken, fish, or seafood), do you take an iron supplement? | O Yes | O No | O Unsure |
| | Have you ever been diagnosed as having iron deficiency anemia? | O No | O Yes | O Unsure |
| | Do you or your family ever struggle to put food on the table? | O No | O Yes | O Unsure |
| | **For females:** Do you have excessive menstrual bleeding or other blood loss? | O No | O Yes | O Unsure |
| | **For females:** Does your period last more than 5 days? | O No | O Yes | O Unsure |
| **Dyslipidemia** | Do you have parents, grandparents, or aunts or uncles who have had a stroke or heart problem before age 55 (males) or 65 (females)? | O No | O Yes | O Unsure |
| | Do you have a parent with an elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication? | O No | O Yes | O Unsure |
| | Do you smoke cigarettes or use e-cigarettes? | O No | O Yes | O Unsure |
| **Sexually transmitted infections/ HIV** | Have you ever had sex, including intercourse or oral sex? **IF NO, SKIP TO THE NEXT SECTION (HIV).** | O No | O Yes | O Unsure |
| | Are you having unprotected sex? | O No | O Yes | O Unsure |
| | Are you having sex with multiple partners or anonymous partners? | O No | O Yes | O Unsure |
| | Are you or any of your past or current sexual partners bisexual? | O No | O Yes | O Unsure |
| | Have you ever been treated for a sexually transmitted infection? | O No | O Yes | O Unsure |
| | Have any of your past or current sex partners been infected with HIV or used injection drugs? | O No | O Yes | O Unsure |
| | Do you trade sex for money or drugs or have sex partners who do? | O No | O Yes | O Unsure |
| | **For males:** Have you ever had sex with other males? | O No | O Yes | O Unsure |
| **HIV** | Do you now use or have you ever used injection drugs? | O No | O Yes | O Unsure |
| **Tuberculosis** | Are you infected with HIV? | O No | O Yes | O Unsure |
| | Were you or was any household member born in, or has he or she traveled to, a country where tuberculosis is common (this includes countries in Africa, Asia, Latin America, and Eastern Europe)? | O No | O Yes | O Unsure |
| | Have you had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result? | O No | O Yes | O Unsure |
| **Vision** | Have you ever failed a school vision screening test? | O No | O Yes | O Unsure |
| | Do you have concerns about your vision? | O No | O Yes | O Unsure |
| | Do you have trouble with near or far vision? | O No | O Yes | O Unsure |
| | Do you tend to squint? | O No | O Yes | O Unsure |

## ANTICIPATORY GUIDANCE

### How are things going for you and your family?

### HOW YOU ARE DOING

| **Interpersonal Violence** | | | |
|---|---|---|---|
| Do you get along with the people you live with? | O Yes | O Sometimes | O No |
| Do you have ways that help you deal with feeling angry? | O Yes | O Sometimes | O No |
| Have you been in a fight in the past 12 months? | O No | O Sometimes | O Yes |
| Do you know anyone in a gang? | O No | O Sometimes | O Yes |
| Do you belong to a gang? | O No | O Sometimes | O Yes |

**PATIENT NAME:** _____ **DATE:** _____

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# 18 THROUGH 21 YEAR VISITS

## HOW YOU ARE DOING (*CONTINUED*)

| **Interpersonal Violence (*continued*)** | | | |
|---|---|---|---|
| Have you ever been hit, slapped, or physically hurt while on a date? | O No | O Sometimes | O Yes |
| Have you ever been touched in a sexual way against your wishes or without your consent? | O No | O Sometimes | O Yes |
| Have you ever been forced to have sexual intercourse? | O No | O Sometimes | O Yes |
| Have you been in a relationship with a person who threatens you physically or hurts you? | O No | O Sometimes | O Yes |
| Do you feel threatened by anyone? | O No | O Sometimes | O Yes |
| Are you worried that you might ever hurt someone else? | O No | O Sometimes | O Yes |
| **Living Situation and Food Security** | | | |
| Do you feel safe in your current living situation? | O Yes | O Sometimes | O No |
| In the past 12 months, did you worry that your food would run out before you got money to buy more? | O No | O Sometimes | O Yes |
| In the past 12 months, did the food you bought not last, and you did not have money to buy more? | O No | O Sometimes | O Yes |
| **Tobacco, E-cigarettes, Alcohol, and Drugs** | | | |
| Is there anyone in your life whose tobacco, alcohol, or drug use concerns you? | O No | O Sometimes | O Yes |
| **Connectedness With Family and Peers** | | | |
| Do you have a close friend? | O Yes | O Sometimes | O No |
| Do you get along with members of your family? | O Yes | O Sometimes | O No |
| **Connectedness With Community** | | | |
| Do you have activities you like to do after school or work or on the weekends? | O Yes | O Sometimes | O No |
| Do you help others out at home, at school, or in your community? | O Yes | O Sometimes | O No |
| **School Performance** | | | |
| Have you graduated from high school or completed a GED? | O Yes | O Sometimes | O No |
| Do you have plans for work or school? | O Yes | O Sometimes | O No |
| **Coping With Stress and Decision-making** | | | |
| Do you feel really stressed out all the time? | O No | O Sometimes | O Yes |
| Do you have strategies to reduce or relieve your stress? | O Yes | O Sometimes | O No |

## YOUR DAILY LIFE

| **Healthy Teeth** | | | |
|---|---|---|---|
| Do you brush your teeth twice a day? | O Yes | O Sometimes | O No |
| Do you floss your teeth once a day? | O Yes | O Sometimes | O No |
| Do you see the dentist regularly? | O Yes | O Sometimes | O No |
| Do you have trouble accessing dental care? | O No | O Sometimes | O Yes |
| **Body Image** | | | |
| Do you have any concerns about your weight? | O No | O Sometimes | O Yes |
| Are you currently doing anything to try to gain or lose weight? | O No | O Sometimes | O Yes |
| **Healthy Eating** | | | |
| Do you have access to healthy food options at home and school? | O Yes | O Sometimes | O No |
| Do you eat fruits and vegetables every day? | O Yes | O Sometimes | O No |
| Do you have milk, yogurt, cheese, or other foods that contain calcium every day? | O Yes | O Sometimes | O No |
| Do you drink juice, soda, sports drinks, or energy drinks? | O No | O Sometimes | O Yes |
| Do you ever skip meals? | O No | O Sometimes | O Yes |
| Do you eat meals together with your family? | O Yes | O Sometimes | O No |

**PATIENT NAME:** _____ **DATE:** _____

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# 18 THROUGH 21 YEAR VISITS

## YOUR DAILY LIFE (*CONTINUED*)

| **Physical Activity and Sleep** | | | |
|---|---|---|---|
| Are you physically active most days? This includes running, playing sports, or doing physically active things with friends. | O Yes | O Sometimes | O No |
| How much time do you spend on screen time unrelated to work or school each day? | _____ hours | | |
| Do you have a regular bedtime? | O Yes | O Sometimes | O No |
| Do you have trouble getting to sleep at night or waking up in the morning? | O No | O Sometimes | O Yes |
| **Transition to Adult Health Care** | | | |
| Do you feel confident about your ability to begin seeing an adult doctor? | O Yes | O Sometimes | O No |
| Do you have health insurance coverage? | O Yes | O Sometimes | O No |
| Do you know your medical conditions, medications, allergies, and family history? | O Yes | O Sometimes | O No |

## EMOTIONAL WELL-BEING

| **Mood and Mental Health** | | | |
|---|---|---|---|
| Do you harm yourself, such as by cutting, hitting, or pinching yourself? | O No | O Sometimes | O Yes |
| **Sexuality** | | | |
| Do you have any questions about your gender identity? | O No | O Sometimes | O Yes |

## HEALTHY BEHAVIOR CHOICES

| **Romantic Relationships and Sexual Activity** | | | |
|---|---|---|---|
| If you have been in romantic relationships, have you always felt safe and respected? | O Yes | O Sometimes | O No |
| Have you ever had sex, including oral, vaginal, or anal sex?<br>*If not, skip to the next section.* | O No | O Sometimes | O Yes |
| Have you had multiple partners in the past year? | O No | O Sometimes | O Yes |
| Have you had both male and female partners? | O No | O Sometimes | O Yes |
| Do you and your partner use condoms every time? | O Yes | O Sometimes | O No |
| Do you and your partner always use another form of birth control along with a condom? | O Yes | O Sometimes | O No |
| Are you aware of emergency contraception? | O Yes | O Sometimes | O No |
| **Tobacco, E-cigarettes, Alcohol, and Prescription or Street Drugs** | | | |
| Do you smoke cigarettes or use e-cigarettes? | O No | O Sometimes | O Yes |
| Do you chew tobacco or use other tobacco products? | O No | O Sometimes | O Yes |
| Do you drink alcohol? | O No | O Sometimes | O Yes |
| Have you used drugs, including marijuana, street drugs, inhalants, or steroids? | O No | O Sometimes | O Yes |
| Have you ever taken prescription drugs that were not given to you for a medical condition? | O No | O Sometimes | O Yes |
| **Acoustic Trauma** | | | |
| Do you use earplugs or sound-canceling headphones to protect your hearing around loud noises or at concerts? | O Yes | O Sometimes | O No |
| Do you often listen to loud music? | O No | O Sometimes | O Yes |

## STAYING SAFE

| **Seat Belt and Helmet Use** | | | |
|---|---|---|---|
| Do you always wear a lap and shoulder seat belt? | O Yes | O Sometimes | O No |
| Do you always wear a helmet to protect your head when you ride a bike, a skateboard, a motorcycle, or an ATV? | O Yes | O Sometimes | O No |
| Do you ever use your phone or tablet while driving, even at stop signs? | O No | O Sometimes | O Yes |
| Do you have someone you can call for a ride if you feel unsafe driving yourself or riding with someone else? | O Yes | O Sometimes | O No |

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# 18 THROUGH 21 YEAR VISITS

## STAYING SAFE (*CONTINUED*)

| | | | |
|---|---|---|---|
| **Sun Protection** | | | |
| Do you use sunscreen? | O Yes | O Sometimes | O No |
| Do you visit tanning parlors? | O No | O Sometimes | O Yes |
| **Gun Safety** | | | |
| Do you have access to guns? | O No | O Sometimes | O Yes |
| Have you carried a weapon to school or work? | O No | O Sometimes | O Yes |

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition

For more information, go to https://brightfutures.aap.org.

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