CLEAR FORM

PATIENT NAME: _____ **DATE:** _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
15 THROUGH 17 YEAR VISITS FOR PARENTS

Bright Futures™

To provide you and your teen with the best possible health care, we would like to know how things are going. Please answer all the questions. Thank you.

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 YOUR TEEN.

What excites or delights you most about your teen?

Does your teen have special health care needs? ○ **No** ○ **Yes,** describe:

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

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

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

YOUR GROWING AND DEVELOPING TEEN

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

- ☐ My teen does things that help her have a healthy lifestyle, such as eating healthy foods, being physically active, and keeping herself safe.
- ☐ My teen has at least one adult in his life who cares about him and knows he can go to if he needs help.
- ☐ My teen has at least one friend or a group of friends who she feels comfortable around.
- ☐ My teen helps others by himself or by working with a group in school, a faith-based organization, or the community.
- ☐ My teen is able to bounce back when things don't go her way.
- ☐ My teen feels hopeful and self-confident.
- ☐ My teen is becoming more independent and making more decisions on his own as he gets older.

PATIENT NAME: _____ **DATE:** _____

Please print.

15 THROUGH 17 YEAR VISITS FOR PARENTS

RISK ASSESSMENT

Anemia	Does your teen's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	O Yes	O No	O Unsure
	Has your teen ever been diagnosed with iron deficiency anemia?	O No	O Yes	O Unsure
	Does your family ever struggle to put food on the table?	O No	O Yes	O Unsure
	If your teen is female, does she have excessive menstrual bleeding or other blood loss?	O No	O Yes	O Unsure
	If your teen is female, does her period last more than 5 days?	O No	O Yes	O Unsure
Dyslipidemia	Does your teen 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
	Does your teen 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
Hearing	Do you have concerns about how your teen hears?	O No	O Yes	O Unsure
Oral health	Does your teen's primary water source contain fluoride?	O Yes	O No	O Unsure
Sexually transmitted infections/ HIV	Teens who are sexually active are at risk of acquiring sexually transmitted infections, including HIV. Teens who use injection drugs are at risk of acquiring HIV. Are you concerned that your teen might be at risk?	O No	O Yes	O Unsure
Tuberculosis	Is your teen infected with HIV?	O No	O Yes	O Unsure
	Was your teen or 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
	Has your teen 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	Do you have concerns about how your teen sees?	O No	O Yes	O Unsure
	Does your teen have trouble with near or far vision?	O No	O Yes	O Unsure
	Has your teen ever failed a school vision screening test?	O No	O Yes	O Unsure
	Does your teen tend to squint?	O No	O Yes	O Unsure

ANTICIPATORY GUIDANCE

How are things going for you, your teen, and your family?

YOUR FAMILY'S HEALTH AND WELL-BEING

Interpersonal Violence (Fighting and Bullying)			
Are there frequent reports of violence in your community or school?	O No	O Sometimes	O Yes
Is your teen involved in that violence?	O No	O Sometimes	O Yes
Has your teen ever been threatened with physical harm or been injured in a fight?	O No	O Sometimes	O Yes
Has your teen bullied others?	O No	O Sometimes	O Yes
Has your teen been suspended from school because of fighting, bullying, or carrying a weapon?	O No	O Sometimes	O Yes
Do you know your teen's friends and the activities they participate in or attend?	O Yes	O Sometimes	O No
If your teen is in a relationship, is it respectful? O NA	O Yes	O Sometimes	O No
Would your teen tell you if someone pressured or forced her to have sex?	O Yes	O Sometimes	O No
Living Situation and Food Security			
Do you have concerns about your living situation?	O No	O Sometimes	O Yes
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
Alcohol and Drugs			
Is there anyone in your teen's life whose alcohol or drug use concerns you?	O No	O Sometimes	O Yes

PATIENT NAME: _____ **DATE:** _____

Please print.

15 THROUGH 17 YEAR VISITS FOR PARENTS

YOUR FAMILY'S HEALTH AND WELL-BEING (*CONTINUED*)

Connectedness With Family and Peers			
Does your family get along well with each other?	O Yes	O Sometimes	O No
Does your family do things together?	O Yes	O Sometimes	O No
Does your teen have chores or responsibilities at home?	O Yes	O Sometimes	O No
Do you set clear rules and expectations for your teen?	O Yes	O Sometimes	O No
Connectedness With Community			
Does your teen have interests outside of school?	O Yes	O Sometimes	O No
Are there things your teen does that you are proud of?	O Yes	O Sometimes	O No
School Performance			
Does your teen get to school on time?	O Yes	O Sometimes	O No
Does your teen attend school almost every day?	O Yes	O Sometimes	O No
Do you recognize your teen's successes and support his efforts?	O Yes	O Sometimes	O No
Does your teen have plans for after high school?	O Yes	O Sometimes	O No
Coping With Stress and Decision-making			
Have you talked with your teen about ways to deal with stress?	O Yes	O Sometimes	O No
Do you help your teen make decisions and solve problems?	O Yes	O Sometimes	O No

YOUR GROWING AND CHANGING TEEN

Healthy Teeth			
Does your teen see the dentist regularly?	O Yes	O Sometimes	O No
Do you have trouble getting dental care?	O No	O Sometimes	O Yes
Body Image			
Do you have any concerns about your teen's weight, eating habits, or physical activity?	O No	O Sometimes	O Yes
Does your teen talk about getting fat or dieting to lose weight?	O No	O Sometimes	O Yes
Healthy Eating			
Do you think your teen eats healthy foods?	O Yes	O Sometimes	O No
Do you have any difficulty getting healthy food for your family?	O No	O Sometimes	O Yes
Do you eat meals together as a family?	O Yes	O Sometimes	O No
Physical Activity and Sleep			
Is your teen physically active at least 1 hour a day? This includes running, playing sports, or doing physically active things with friends.	O Yes	O Sometimes	O No
Are there opportunities to safely exercise outside in your neighborhood?	O Yes	O Sometimes	O No
Do you and your teen participate in physical activities together?	O Yes	O Sometimes	O No
How much time does your teen spend on recreational screen time each day?	_____ hours		
Does your teen have a TV, computer, tablet, or smartphone in his bedroom?	O No	O Sometimes	O Yes
Has your family made a media use plan to help everyone balance time spent on media with other family and personal activities?	O Yes	O Sometimes	O No
Does your teen have a regular bedtime?	O Yes	O Sometimes	O No
Do you think your teen gets enough sleep?	O Yes	O Sometimes	O No

YOUR TEEN'S EMOTIONAL WELL-BEING

Mood and Mental Health			
Have you noticed any changes in your teen's weight, sleep habits, or behaviors?	O No	O Sometimes	O Yes
Is your teen frequently irritable?	O No	O Sometimes	O Yes
Do you have concerns about your teen's emotional health, such as being frequently sad or depressed?	O No	O Sometimes	O Yes
Do you think your teen worries too much or appears overly anxious?	O No	O Sometimes	O Yes

PATIENT NAME: _____ **DATE:** _____

Please print.

15 THROUGH 17 YEAR VISITS FOR PARENTS

YOUR TEEN'S EMOTIONAL WELL-BEING (*CONTINUED*)

Sexuality			
Have you talked with your teen about relationships, dating, and sex?	O Yes	O Sometimes	O No
Have you talked with your teen about his sexuality?	O Yes	O Sometimes	O No
Do you have house rules about curfews, parties, dating, and friends?	O Yes	O Sometimes	O No
Do you know where your teen's friends are and what they're doing?	O Yes	O Sometimes	O No

HEALTHY BEHAVIOR CHOICES

Sexual Activity			
Are you worried about sexual pressures on your teen?	O No	O Sometimes	O Yes
Substance Use			
Have you talked with your teen about alcohol and drug use?	O Yes	O Sometimes	O No
To your knowledge, is your teen currently using alcohol or drugs, or has she used them in the past?	O No	O Sometimes	O Yes
Have you discussed consequences if you discover your teen is using tobacco, alcohol, or drugs?	O Yes	O Sometimes	O No
Acoustic Trauma			
Does your teen often listen to loud music?	O No	O Sometimes	O Yes

SAFETY

Seat Belt and Helmet Use			
Does your teen always wear a lap and shoulder seat belt and bicycle helmet?	O Yes	O Sometimes	O No
Do you have rules or restrictions around driving?	O Yes	O Sometimes	O No
Sun Protection			
Does your teen use sunscreen?	O Yes	O Sometimes	O No
Gun Safety			
Is there a gun in your home or the homes where your teen spends time?	O No	O Sometimes	O Yes
If yes, is the gun unloaded and locked up?	O Yes	O Sometimes	O No
If yes, is the ammunition stored and locked up separately from the gun?	O Yes	O Sometimes	O No
Have you talked with your teen about gun safety?	O Yes	O Sometimes	O No

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

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

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®