



Bright Futures Previsit Questionnaire 15 to 17 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 last year?

Do you have any special health care needs? No Yes Unsure, 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 keep active <input type="checkbox"/> Protecting your ears from loud noise |
| School and Friends | <input type="checkbox"/> Your relationship with your family <input type="checkbox"/> Your friends <input type="checkbox"/> Girlfriend or boyfriend <input type="checkbox"/> How you are doing in school <input type="checkbox"/> Organizing your time to get things done <input type="checkbox"/> Plans after high school |
| How You Are Feeling | <input type="checkbox"/> Dealing with stress <input type="checkbox"/> Keeping under control <input type="checkbox"/> Sexuality <input type="checkbox"/> Feeling sad <input type="checkbox"/> Feeling anxious <input type="checkbox"/> Feeling irritable <input type="checkbox"/> Keeping a positive attitude |
| 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"/> Decisions about sex, alcohol, and drugs <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, alcohol, and drugs |
| Violence and Injuries | <input type="checkbox"/> Car safety <input type="checkbox"/> Using a helmet <input type="checkbox"/> Driving rules for new teen drivers <input type="checkbox"/> Gun safety <input type="checkbox"/> Dating violence or abuse <input type="checkbox"/> Bullying or trouble with other kids <input type="checkbox"/> Keeping yourself and your friends safe in risky situations |

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 |
| | 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 |
| Cervical Dysplasia | 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
- EMOTIONAL WELL-BEING
- 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

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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

15 to 17 Year Visits

Your Daily Life

- Visit the dentist at least twice a year.
- Brush your teeth at least twice a day and floss once a day.
- Wear your mouth guard when playing sports.
- Protect your hearing at work, home, and concerts.
- Try to eat healthy foods.
 - 5 fruits and vegetables a day
 - 3 cups of low-fat milk, yogurt, or cheese
- Eating breakfast is very important.
- Drink plenty of water. Choose water instead of soda.
- Eat with your family often.
- Aim for 1 hour of vigorous physical activity every day.
- Try to limit watching TV, playing video games, or playing on the computer to 2 hours a day (outside of homework time).
- Be proud of yourself when you do something good.

PHYSICAL GROWTH AND DEVELOPMENT

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.
- Support friends who choose not to use tobacco, alcohol, drugs, steroids, or diet pills.
- Insist that seat belts be used by everyone.
- Always be a safe and cautious driver.
 - Limit the number of friends in the car, nighttime driving, and distractions.
- Never allow physical harm of yourself or others at home or school.
- Learn how to deal with conflict without using violence.
- Understand that healthy dating relationships are built on respect and that saying “no” is OK.
- Fighting and carrying weapons can be dangerous.

VIOLENCE AND INJURY PREVENTION

School and Friends

- Set high goals for yourself in school, your future, and other activities.
- Read often.
- Ask for help when you need it.
- Find new activities you enjoy.
- Consider volunteering and helping others in the community with an issue that interests or concerns you.
- Be a part of positive after-school activities and sports.
- Form healthy friendships and find fun, safe things to do with friends.
- Spend time with your family and help at home.
- Take responsibility for getting your homework done and getting to school or work on time.

SOCIAL AND ACADEMIC COMPETENCE

Healthy Behavior Choices

- Talk with your parents about your values and expectations for drinking, drug use, tobacco use, driving, and sex.
- Talk with your parents when you need support or help in making healthy decisions about sex.
- Find safe activities at school and in the community.
- Make healthy decisions about sex, tobacco, alcohol, and other drugs.
- Follow your family's rules.

RISK REDUCTION

Your Feelings

- Talk with your parents about your hopes and concerns.
- Figure out healthy ways to deal with stress.
- Look for ways you can help out at home.
- Develop ways to solve problems and make good decisions.
- It's important for you to have accurate information about sexuality, your physical development, and your sexual feelings. Please ask me if you have any questions.

EMOTIONAL WELL-BEING



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Bright Futures Parent Handout 15 to 17 Year Visits

Here are some suggestions from Bright Futures experts that may be of value to your family.

Your Growing and Changing Teen

PHYSICAL GROWTH AND DEVELOPMENT

- Help your teen visit the dentist at least twice a year.
- Encourage your teen to protect her hearing at work, home, and concerts.
- Keep a variety of healthy foods at home.
- Help your teen get enough calcium.
- Encourage 1 hour of vigorous physical activity a day.
- Praise your teen when he does something well, not just when he looks good.

Healthy Behavior Choices

RISK REDUCTION

- Talk with your teen about your values and your expectations on drinking, drug use, tobacco use, driving, and sex.
- Be there for your teen when she needs support or help in making healthy decision about her sexual behavior.
- Support safe activities at school and in the community.
- Praise your teen for healthy decisions about sex, tobacco, alcohol, and other drugs.

Violence and Injuries

VIOLENCE AND INJURY PREVENTION

- Do not tolerate drinking and driving.
- Insist that seat belts be used by everyone.
- Set expectations for safe driving.
 - Limit the number of friends in the car, nighttime driving, and distractions.
- Never allow physical harm of yourself, your teen, or others at home or school.
- Remove guns from your home. If you must keep a gun in your home, make sure it is unloaded and locked with ammunition locked in a separate place.
- Teach your teen how to deal with conflict without using violence.
- Make sure your teen understands that healthy dating relationships are built on respect and that saying “no” is OK.

Feelings and Family

EMOTIONAL WELL-BEING

- Set aside time to be with your teen and really listen to his hopes and concerns.
- Support your teen as he figures out ways to deal with stress.
- Support your teen in solving problems and making decisions.
- If you are concerned that your teen is sad, depressed, nervous, irritable, hopeless, or angry, talk with me.

School and Friends

SOCIAL AND ACADEMIC COMPETENCE

- Praise positive efforts and success in school and other activities.
- Encourage reading.
- Help your teen find new activities she enjoys.
- Encourage your teen to help others in the community.
- Help your teen find and be a part of positive after-school activities and sports.
- Encourage healthy friendships and fun, safe things to do with friends.
- Know your teen's friends and their parents, where your teen is, and what he is doing at all times.
- Check in with your teen's teacher about her grades on tests.
 - Attend back-to-school events if possible.
 - Attend parent-teacher conferences if possible.



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