



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 <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; text-align: center; line-height: 20px;">M</div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; text-align: center; line-height: 20px;">F</div>	

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

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 _____

☐ 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
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
This American Academy of Pediatrics Visit Documentation Form is consistent with Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition.
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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?
R - Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
A - Do you ever use alcohol or drugs while you are by yourself, ALONE?
F - Do you ever FORGET things you did while using alcohol or drugs?
F - Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?
T - Have you gotten into TROUBLE while you were using alcohol or drugs?
Counseling/Recommendations

Safety
Impaired/Distracted driving
Sports/recreation safety
Guns
Peer violence
Dating violence
Counseling/Recommendations

Sex
Oral sex
Has had sexual intercourse (vaginal, anal)
Age of onset of sexual activity
Number of partners
Gender of partners
Sexual orientation
Condom use
Contraception
Previous pregnancy
Previous STI
Laboratory/Screening results
Pregnancy test
Pap smear
Chlamydia/Gonorrhea, source
Syphilis
HIV
STI screening laboratory results (specify)
Counseling/Recommendations

Suicidality/Mental Health
Depression
Anxiety
Suicide ideation
Suicide attempts
History of psycholog ic counseling
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

- 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

- 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

- 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

- 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

- 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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