PATIENT NAME: _____ **DATE:** _____

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
18 THROUGH 21 YEAR VISITS

Bright Futures™

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

RISK ASSESSMENT

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

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

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

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? *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

STAYING SAFE

Seat Belt and Helmet Use			
Do you always wear a lap and shoulder seat belt?	○ Yes	○ Sometimes	○ No
Do you always wear a helmet to protect your head when you ride a bike, a skateboard, a motorcycle, or an ATV?	○ Yes	○ Sometimes	○ No
Do you ever use your phone or tablet while driving, even at stop signs?	○ No	○ Sometimes	○ Yes
Do you have someone you can call for a ride if you feel unsafe driving yourself or riding with someone else?	○ Yes	○ Sometimes	○ No
Sun Protection			
Do you use sunscreen?	○ Yes	○ Sometimes	○ No
Do you visit tanning parlors?	○ No	○ Sometimes	○ Yes
Gun Safety			
Do you have access to guns?	○ No	○ Sometimes	○ Yes
Have you carried a weapon to school or work?	○ No	○ Sometimes	○ Yes