

American Academy of Pediatrics



BRIGHT FUTURES PREVISIT QUESTIONNAIRE 15 THROUGH 17 YEAR VISITS FOR PARENTS

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:

Blank text area for describing concerns or questions.

TELL US ABOUT YOUR TEEN.

What excites or delights you most about your teen?

Blank text area for describing what excites or delights the parent about their teen.

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

Blank text area for describing special health care needs.

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

Blank text area for describing major changes in life.

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

Blank text area for describing new medical problems in relatives.

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

Blank text area for describing smoking or e-cigarette use in the household.

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.

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?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	Has your teen ever been diagnosed with iron deficiency anemia?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your family ever struggle to put food on the table?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	If your teen is female , does she have excessive menstrual bleeding or other blood loss?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	If your teen is female , does her period last more than 5 days?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 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)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your teen have a parent with an elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Hearing	Do you have concerns about how your teen hears?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Oral health	Does your teen's primary water source contain fluoride?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> 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?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Tuberculosis	Is your teen infected with HIV?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 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)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Has your teen had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Vision	Do you have concerns about how your teen sees?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your teen have trouble with near or far vision?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Has your teen ever failed a school vision screening test?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your teen tend to squint?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 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?		<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Is your teen involved in that violence?		<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Has your teen ever been threatened with physical harm or been injured in a fight?		<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Has your teen bullied others?		<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Has your teen been suspended from school because of fighting, bullying, or carrying a weapon?		<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you know your teen's friends and the activities they participate in or attend?		<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
If your teen is in a relationship, is it respectful?		<input type="radio"/> NA	<input type="radio"/> Yes	<input type="radio"/> Sometimes
Would your teen tell you if someone pressured or forced her to have sex?		<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Living Situation and Food Security				
Do you have concerns about your living situation?		<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
In the past 12 months, did you worry that your food would run out before you got money to buy more?		<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
In the past 12 months, did the food you bought not last, and you did not have money to buy more?		<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Alcohol and Drugs				
Is there anyone in your teen's life whose alcohol or drug use concerns you?		<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes

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

YOUR GROWING AND CHANGING TEEN

Healthy Teeth			
Does your teen see the dentist regularly?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have trouble getting dental care?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Body Image			
Do you have any concerns about your teen's weight, eating habits, or physical activity?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Does your teen talk about getting fat or dieting to lose weight?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Healthy Eating			
Do you think your teen eats healthy foods?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have any difficulty getting healthy food for your family?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you eat meals together as a family?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> 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.	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Are there opportunities to safely exercise outside in your neighborhood?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you and your teen participate in physical activities together?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> 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?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Has your family made a media use plan to help everyone balance time spent on media with other family and personal activities?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Does your teen have a regular bedtime?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you think your teen gets enough sleep?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> 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?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Is your teen frequently irritable?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you have concerns about your teen's emotional health, such as being frequently sad or depressed?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you think your teen worries too much or appears overly anxious?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes

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?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Have you talked with your teen about his sexuality?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have house rules about curfews, parties, dating, and friends?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you know where your teen's friends are and what they're doing?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No

HEALTHY BEHAVIOR CHOICES

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

SAFETY

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

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DEDICATED TO THE HEALTH OF ALL CHILDREN®



The information contained in this questionnaire should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances. Original questionnaire included as part of the *Bright Futures Tool and Resource Kit*, 2nd Edition.

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