

American Academy of Pediatrics



BRIGHT FUTURES PREVISIT QUESTIONNAIRE

18 THROUGH 21 YEAR VISITS

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 have any special health care needs? No Yes, describe:

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

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

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

GROWING AND DEVELOPING

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

- | | |
|---|--|
| <input type="checkbox"/> I do things that help me have a healthy lifestyle, such as eating healthy foods, being physically active, and keeping myself safe. | <input type="checkbox"/> I help others. |
| <input type="checkbox"/> I have at least one adult in my life who I know I can go to if I need help. | <input type="checkbox"/> I am able to bounce back when life doesn't go my way. |
| <input type="checkbox"/> I have a friend or a group of friends that I feel comfortable to be around. | <input type="checkbox"/> I feel hopeful and confident. |
| | <input type="checkbox"/> I am becoming more independent and I make more of my own decisions. |

Please print.

18 THROUGH 21 YEAR VISITS

RISK ASSESSMENT

Anemia	Does your 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
	Do you eat a vegetarian diet (do not eat red meat, chicken, fish, or seafood)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	If you are a vegetarian (do not eat red meat, chicken, fish, or seafood), do you take an iron supplement?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	Have you ever been diagnosed as having iron deficiency anemia?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do you or your family ever struggle to put food on the table?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	For females: Do you have excessive menstrual bleeding or other blood loss?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	For females: Does your period last more than 5 days?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 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)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do you 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
	Do you smoke cigarettes or use e-cigarettes?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Sexually transmitted infections/ HIV	Have you ever had sex, including intercourse or oral sex? IF NO, SKIP TO THE NEXT SECTION (HIV).	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Are you having unprotected sex?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Are you having sex with multiple partners or anonymous partners?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Are you or any of your past or current sexual partners bisexual?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Have you ever been treated for a sexually transmitted infection?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Have any of your past or current sex partners been infected with HIV or used injection drugs?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do you trade sex for money or drugs or have sex partners who do? For males: Have you ever had sex with other males?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
HIV	Do you now use or have you ever used injection drugs?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Tuberculosis	Are you infected with HIV?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 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)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Have you 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	Have you ever failed a school vision screening test?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do you have concerns about your vision?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do you have trouble with near or far vision?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do you tend to squint?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure

ANTICIPATORY GUIDANCE

How are things going for you and your family?

HOW YOU ARE DOING

Interpersonal Violence			
Do you get along with the people you live with?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have ways that help you deal with feeling angry?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Have you been in a fight in the past 12 months?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you know anyone in a gang?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you belong to a gang?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes

Please print.

18 THROUGH 21 YEAR VISITS

HOW YOU ARE DOING (CONTINUED)

Interpersonal Violence (continued)			
Have you ever been hit, slapped, or physically hurt while on a date?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you ever been touched in a sexual way against your wishes or without your consent?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you ever been forced to have sexual intercourse?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you been in a relationship with a person who threatens you physically or hurts you?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you feel threatened by anyone?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Are you worried that you might ever hurt someone else?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Living Situation and Food Security			
Do you feel safe in your current living situation?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
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
Tobacco, E-cigarettes, Alcohol, and Drugs			
Is there anyone in your life whose tobacco, alcohol, or drug use concerns you?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Connectedness With Family and Peers			
Do you have a close friend?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you get along with members of your family?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Connectedness With Community			
Do you have activities you like to do after school or work or on the weekends?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you help others out at home, at school, or in your community?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
School Performance			
Have you graduated from high school or completed a GED?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have plans for work or school?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Coping With Stress and Decision-making			
Do you feel really stressed out all the time?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you have strategies to reduce or relieve your stress?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No

YOUR DAILY LIFE

Healthy Teeth			
Do you brush your teeth twice a day?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you floss your teeth once a day?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you see the dentist regularly?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have trouble accessing dental care?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Body Image			
Do you have any concerns about your weight?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Are you currently doing anything to try to gain or lose weight?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Healthy Eating			
Do you have access to healthy food options at home and school?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you eat fruits and vegetables every day?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have milk, yogurt, cheese, or other foods that contain calcium every day?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you drink juice, soda, sports drinks, or energy drinks?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you ever skip meals?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you eat meals together with your family?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No

18 THROUGH 21 YEAR VISITS

YOUR DAILY LIFE (CONTINUED)

Physical Activity and Sleep			
Are you physically active most days? This includes running, playing sports, or doing physically active things with friends.	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
How much time do you spend on screen time unrelated to work or school each day?	_____ hours		
Do you have a regular bedtime?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have trouble getting to sleep at night or waking up in the morning?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Transition to Adult Health Care			
Do you feel confident about your ability to begin seeing an adult doctor?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have health insurance coverage?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you know your medical conditions, medications, allergies, and family history?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No

EMOTIONAL WELL-BEING

Mood and Mental Health			
Do you harm yourself, such as by cutting, hitting, or pinching yourself?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Sexuality			
Do you have any questions about your gender identity?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes

HEALTHY BEHAVIOR CHOICES

Romantic Relationships and Sexual Activity			
If you have been in romantic relationships, have you always felt safe and respected?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Have you ever had sex, including oral, vaginal, or anal sex? <i>If not, skip to the next section.</i>	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you had multiple partners in the past year?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you had both male and female partners?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you and your partner use condoms every time?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you and your partner always use another form of birth control along with a condom?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Are you aware of emergency contraception?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Tobacco, E-cigarettes, Alcohol, and Prescription or Street Drugs			
Do you smoke cigarettes or use e-cigarettes?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you chew tobacco or use other tobacco products?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you drink alcohol?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you used drugs, including marijuana, street drugs, inhalants, or steroids?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you ever taken prescription drugs that were not given to you for a medical condition?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Acoustic Trauma			
Do you use earplugs or sound-canceling headphones to protect your hearing around loud noises or at concerts?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you often listen to loud music?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes

STAYING SAFE

Seat Belt and Helmet Use			
Do you always wear a lap and shoulder seat belt?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you always wear a helmet to protect your head when you ride a bike, a skateboard, a motorcycle, or an ATV?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you ever use your phone or tablet while driving, even at stop signs?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you have someone you can call for a ride if you feel unsafe driving yourself or riding with someone else?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No

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STAYING SAFE (CONTINUED)

Sun Protection			
Do you use sunscreen?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you visit tanning parlors?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Gun Safety			
Do you have access to guns?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you carried a weapon to school or work?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes

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®



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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