

PATIENT NAME: _____

Please print.

DATE: _____

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:

TELL US ABOUT YOUR TEEN.

What excites or delights you most about your teen?

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

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

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

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

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	<input type="radio"/> No
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	

Please print.

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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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:

Blank space for patient input.

TELL US ABOUT YOURSELF.

What are you most proud of about yourself?

Blank space for patient input.

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

Blank space for patient input.

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

Blank space for patient input.

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

Blank space for patient input.

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.

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

Please print.

15 THROUGH 17 YEAR VISITS FOR PATIENTS

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
	Does 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
Oral health	Does your primary water source contain fluoride?	<input type="radio"/> Yes	<input type="radio"/> No	<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?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
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	Do you have concerns about your vision?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Have you ever failed a school vision screening test?	<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 (Fighting and Bullying)			
Do you feel safe at home?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you feel safe at school and getting to and from school?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Have you been bullied in person, on the Internet, or through social media?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
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

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15 THROUGH 17 YEAR VISITS FOR PATIENTS

HOW YOU ARE DOING (CONTINUED)

Interpersonal Violence (Fighting and Bullying) (continued)			
Have you ever carried a weapon to school?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you belong to a gang or know anyone in a gang?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you ever been touched in a sexual way that made you feel uncomfortable?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you ever been forced or pressured to do something sexual you didn't want to do?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you ever been in a relationship with someone who threatened or hurt you?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Food Security and Living Situation			
In the past 12 months, have you had trouble having enough food to eat or have concerns that you might not have enough?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
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 get along with your family?	<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
Do you follow your family rules and limits?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you get along with your friends and others at school?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Connectedness With Community			
Do you have interests outside of school?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you do things you are good at or that you are proud of?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
School Performance			
Have you missed more than 2 days of school in any month?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Are you doing well in school?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Are you having any problems in school?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you have plans for what you will do after high school?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Coping With Stress and Decision-making			
Do you have ways to deal with stress?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you worry or feel stressed out much of the time?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes

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 once a day?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you see the dentist twice a year?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you chew gum or tobacco?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
If you play contact sports, do you wear a mouth guard?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
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
Have you ever been teased because of your weight?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Healthy Eating			
Do you have access to healthy food options?	<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

Please print.

15 THROUGH 17 YEAR VISITS FOR PATIENTS

YOUR DAILY LIFE (CONTINUED)

Healthy Eating (continued)			
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
Physical Activity and Sleep			
Are you physically active at least 1 hour every 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
How much time every day do you spend watching TV, playing video games, or using computers, tablets, or smartphones (not counting schoolwork)?	_____ hours		
Do you get 8 or more hours of sleep each night?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have trouble sleeping at night or waking up in the morning?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes

YOUR 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			
Have you talked with your parents about dating and sex?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
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"/> NA	<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 no, skip to the next section.</i>	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes	
Are you currently having sex, including oral sex, with anyone?	<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	
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				
Have you ever smoked cigarettes or used e-cigarettes?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes	
Have you ever drunk alcohol?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes	
Have you ever used drugs, including marijuana or street drugs?	<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 are biking, skateboarding, or skating?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No	
Do you always wear a life jacket when you do water sports?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No	
If you have started driving, do you follow the safety rules for young drivers?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No	
Do you have someone you can call for a ride if you feel unsafe driving yourself or riding with someone else?	<input type="radio"/> NA	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No

PATIENT NAME: _____ DATE: _____

Please print.

15 THROUGH 17 YEAR VISITS FOR PATIENTS

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			
Have you ever carried a gun or knife (even for self-protection)?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
If there is a gun in your home, do you know how to get hold of it?	<input type="radio"/> NA	<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>.



Patient Health Questionnaire (PHQ-9)

Patient Name: _____

Date: _____

Not at all Several days More than
half the days Nearly every
day

1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

- a. Little interest or pleasure in doing things
- b. Feeling down, depressed, or hopeless
- c. Trouble falling/staying asleep, sleeping too much
- d. Feeling tired or having little energy
- e. Poor appetite or overeating
- f. Feeling bad about yourself or that you are a failure or have let yourself or your family down
- g. Trouble concentrating on things, such as reading the newspaper or watching television.
- h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.
- i. Thoughts that you would be better off dead or of hurting yourself in some way.

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult Somewhat Very Extremely
at all difficult difficult difficult