

American Academy of Pediatrics



BRIGHT FUTURES PREVISIT QUESTIONNAIRE

11 THROUGH 14 YEAR VISITS FOR PATIENTS

(SENSITIVE QUESTIONS INCLUDED)

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 (beginning at age 12) 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?

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.

- 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.

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by Jeffrey Davis

Please print.

11 THROUGH 14 YEAR VISITS FOR PATIENTS (SENSITIVE QUESTIONS INCLUDED)

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 |
| | For girls: Do you have excessive menstrual bleeding or other blood loss? | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unsure |
| | For girls: Does your period last more than 5 days? | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unsure |
| Dyslipidemia | 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? | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unsure |
| | For boys: 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 how well you see? | <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) | | | |
|---|---------------------------|---------------------------------|---------------------------|
| Have you been part of a gang or a group that has gotten or could get into trouble? | <input type="radio"/> No | <input type="radio"/> Sometimes | <input type="radio"/> Yes |
| Have you been in a fight in the past 6 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 have ways that help you deal with feeling angry? | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| Do you feel safe at home? | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| Have you ever been bullied in person, on the Internet, or through social media? | <input type="radio"/> No | <input type="radio"/> Sometimes | <input type="radio"/> Yes |
| Have you been in a relationship with a person who threatened you physically or hurt you? | <input type="radio"/> No | <input type="radio"/> Sometimes | <input type="radio"/> Yes |
| Have you ever been touched in a way that made you feel uncomfortable? | <input type="radio"/> No | <input type="radio"/> Sometimes | <input type="radio"/> Yes |
| Has anyone touched your private parts without your agreement or against your wishes? | <input type="radio"/> No | <input type="radio"/> Sometimes | <input type="radio"/> Yes |
| Have you ever been forced or pressured to do something sexually that you didn't want to do? | <input type="radio"/> No | <input type="radio"/> Sometimes | <input type="radio"/> Yes |
| Connectedness With Family and Peers | | | |
| Do you spend time talking with your parents every day? | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| Do your parents praise you when you do something good or learn something new? | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |

Please print.

11 THROUGH 14 YEAR VISITS FOR PATIENTS (SENSITIVE QUESTIONS INCLUDED)

HOW YOU ARE DOING (CONTINUED)

| Connectedness With Family and Peers (continued) | | | |
|---|---------------------------|---------------------------------|---------------------------|
| 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 have an adult you feel connected to? | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| Do you have rules at home and know what happens when you break the rules? | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| Connectedness With Community | | | |
| Do you have activities or things you like to do after school or on the weekends? | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| Do you help others at home, in school, or in your community? | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| School Performance | | | |
| Are you doing well at school? | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| Do you have things you enjoy doing at school? | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| Are you having any problems in school? Are there things you need help figuring out? | <input type="radio"/> No | <input type="radio"/> Sometimes | <input type="radio"/> Yes |
| Do you get extra help or support in any subjects at school? | <input type="radio"/> No | <input type="radio"/> Sometimes | <input type="radio"/> Yes |
| Coping With Stress and Decision-making | | | |
| Do you worry a lot or feel overly stressed out? | <input type="radio"/> No | <input type="radio"/> Sometimes | <input type="radio"/> Yes |
| Do you have things you do to feel better when you are stressed? | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |

YOUR GROWING AND CHANGING BODY

| Healthy Teeth | | | |
|--|---------------------------|---------------------------------|---------------------------|
| Do you brush your teeth twice 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 |
| 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 teased 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 healthy food options at home and in 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 |
| Physical Activity and Sleep | | | |
| Are you physically active at least 1 hour a day? This includes running, playing sports, or active play 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? | <input type="radio"/> No | <input type="radio"/> Sometimes | <input type="radio"/> Yes |

EMOTIONAL WELL-BEING

| | | | |
|---|---------------------------|---------------------------------|---------------------------|
| Do you and your parents argue a lot about what your culture expects of you and what your friends are doing? | <input type="radio"/> No | <input type="radio"/> Sometimes | <input type="radio"/> Yes |
| 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 questions or concerns about how your body is changing (puberty)? | <input type="radio"/> No | <input type="radio"/> Sometimes | <input type="radio"/> Yes |

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EMOTIONAL WELL-BEING (CONTINUED)

| | | | |
|--|--------------------------|---------------------------------|---------------------------|
| For girls: Have you started your period? | <input type="radio"/> No | <input type="radio"/> Sometimes | <input type="radio"/> Yes |
| For girls: If yes, do you have any concerns about your period (such as not regular, heavy bleeding, or bad cramping)? | <input type="radio"/> No | <input type="radio"/> Sometimes | <input type="radio"/> Yes |

HEALTHY BEHAVIOR CHOICES

| Romantic Relationships and Sexual Activity | | | |
|--|---------------------------|---------------------------------|---------------------------|
| Have you ever been in a romantic relationship? | <input type="radio"/> No | <input type="radio"/> Sometimes | <input type="radio"/> Yes |
| If yes, 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 no, skip to the next section.</i> | <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 been offered any drugs? | <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 |
| 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 |
| Substance Use and Riding in a Vehicle | | | |
| Have you ever ridden in a car with someone who has been drinking or using drugs? | <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 riding with someone? | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| 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"/> 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

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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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