



Bright Futures Previsit Questionnaire

18 to 21 Year Visits

For us to provide you with the best possible health care, we would like to get to know you better and know how things are going for you. 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. 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?

What changes or challenges have there been at home since your last visit?

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

Do you live with anyone who uses tobacco or spend time in any place where people smoke? No Yes, describe:

How many hours per day do you watch TV, play video games, and use the computer (not for schoolwork)?

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

Your Growing and Changing Body	<input type="checkbox"/> How your body is changing <input type="checkbox"/> Teeth <input type="checkbox"/> Appearance or body image <input type="checkbox"/> How you feel about yourself <input type="checkbox"/> Healthy eating <input type="checkbox"/> Good ways to be active <input type="checkbox"/> Protecting your ears from loud noise
School and Friends	<input type="checkbox"/> How you are doing in school <input type="checkbox"/> Organizing your time to get things done <input type="checkbox"/> Your job <input type="checkbox"/> Your future plans <input type="checkbox"/> Your friends <input type="checkbox"/> Girlfriend or boyfriend <input type="checkbox"/> Your relationship with your family
How You Are Feeling	<input type="checkbox"/> Dealing with stress <input type="checkbox"/> Keeping under control <input type="checkbox"/> Making decisions on your own <input type="checkbox"/> Sexuality <input type="checkbox"/> Depression <input type="checkbox"/> Feeling anxious <input type="checkbox"/> Feeling irritable <input type="checkbox"/> Feeling sad
Healthy Behavior Choices	<input type="checkbox"/> Pregnancy <input type="checkbox"/> Sexually transmitted infections (STIs) <input type="checkbox"/> Smoking cigarettes <input type="checkbox"/> Drinking alcohol <input type="checkbox"/> Using drugs <input type="checkbox"/> How to avoid risky situations <input type="checkbox"/> How to support friends who don't use alcohol and drugs <input type="checkbox"/> How to follow through with decisions you have made about sex and drugs
Violence and Injuries	<input type="checkbox"/> Avoiding driving distractions <input type="checkbox"/> Drinking and driving <input type="checkbox"/> Gun safety <input type="checkbox"/> Dating violence or abuse

Questions

Vision	Do you complain that the blackboard has become difficult to see?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have you ever failed a school vision screening test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you hold books close to your eyes to read?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you have trouble recognizing faces at a distance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you tend to squint?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Hearing	Do you have a problem hearing over the telephone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you have trouble following the conversation when 2 or more people are talking at the same time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you have trouble hearing with a noisy background?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you find yourself asking people to repeat themselves?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you misunderstand what others are saying and respond inappropriately?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Tuberculosis	Were you born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have you traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have you ever been incarcerated (in jail)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Are you infected with HIV?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Dyslipidemia	Do you have parents or grandparents who have had a stroke or heart problem before age 55?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you have a parent with an elevated blood cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you smoke cigarettes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Anemia	Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unsure
	Have you ever been diagnosed with iron deficiency anemia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure



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Alcohol or Drug Use	Have you ever had an alcoholic drink?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have you ever used marijuana or any other drug to get high?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
STIs	Do you now use or have you ever used injectable drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	For Females Only			
Anemia	Do you have excessive menstrual bleeding or other blood loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your period last more than 5 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
STIs	Have you ever had sex (including intercourse or oral sex)? (If no, skip to Growing and Developing)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have any of your past or current sex partners been infected with HIV, bisexual, or injection drug users?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have you ever been treated for a sexually transmitted infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Are you having unprotected sex with multiple partners?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you trade sex for money or drugs or have sex partners who do?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Cervical Dysplasia	Was your first time having sexual intercourse more than 3 years ago?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Pregnancy	Have you been sexually active without using birth control?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have you been sexually active and had a late or missed period within the last 2 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
For Males Only				
STIs	Have you ever had sex (including intercourse or oral sex)? (If no, skip to Growing and Developing)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have you ever been treated for a sexually transmitted infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Are you having unprotected sex with multiple partners?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have you ever had sex with other men?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you trade sex for money or drugs or have sex partners who do?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have any of your past or current sex partners been infected with HIV, bisexual, or injection drug users?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

Growing and Developing

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

- I engage in behavior that supports a healthy lifestyle, such as eating healthy foods, being active, and keeping myself safe.
- I feel I have at least one responsible adult in my life who cares about me and who I can go to if I need help.
- I feel like I have at least one friend or a group of friends with whom I am comfortable.
- I help others on my own or by working with a group in school, a faith-based organization, or the community.
- I am able to bounce back from life's disappointments.
- I have a sense of hopefulness and self-confidence.
- I have become more independent and made more of my own decisions as I have become older.
- I feel that I am particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting. Describe:



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PHQ-9: Modified for Teens

Name _____

Clinician _____ Date _____

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks?
For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes? Yes No

If you are experiencing any of the problems on this form, 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 at all Somewhat difficult Very difficult Extremely difficult

Has there been a time in the past month when you have had serious thoughts about ending your life? Yes No

Have you **ever**, in your **whole life**, tried to kill yourself or made a suicide attempt? Yes No

For Office Use Only Score 0

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