Barrow Pediatrics
and Adolescent Medicine

Please Follow These Instructions and Bring the Completed Form to Your Visit:

You can: 1) Use a Computer to complete your answers; or 2) Print out a blank form and use a pen to complete your answers. For those with access to a Computer, Option #1 will be the easiest method.

Option #1: Complete the Form using a Computer:

1. Open the downloaded PDF file and complete the Well-Check form using your Computer.
2. **Save all changes.** *You will lose your work* if you do not save your changes before printing out the completed form.
3. Print out the completed Well-Check form as a one-sided document on front-side of pages.
4. Bring the completed, printed form to our office at your appointment time.
5. Give the completed form to our receptionist.

Option #2: Print Out a Blank Form and use a pen to complete your answers.

1. Open the downloaded PDF file and print out a blank Well-Check form as a one-sided document on front-side of pages.
2. Complete the Well-Check form using a pen.
3. Bring the completed, printed form to our office at your appointment time.
4. Give the completed form to our receptionist.

NOTE: Parents of 11-12 year olds, 13-14 year olds, and 15-17 year olds have a separate Parent Well-Check form to complete for your child. This additional form is included in the downloaded PDF form file.

Thank You for Completing Your Child's Well-Check Form in Advance!

This will help reduce the wait time spent at your child's office visit.

CLEAR FORM

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
15 THROUGH 17 YEAR VISITS FOR PATIENTS

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.

- ☐ 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.

PATIENT NAME: _____ DATE: _____

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?	O Yes	O No	O Unsure
	Do you eat a vegetarian diet (do not eat red meat, chicken, fish, or seafood)?	O No	O Yes	O Unsure
	If you are a vegetarian (do not eat red meat, chicken, fish, or seafood), do you take an iron supplement?	O Yes	O No	O Unsure
	Have you ever been diagnosed as having iron deficiency anemia?	O No	O Yes	O Unsure
	Does your family ever struggle to put food on the table?	O No	O Yes	O Unsure
	For females: Do you have excessive menstrual bleeding or other blood loss?	O No	O Yes	O Unsure
	For females: Does your period last more than 5 days?	O No	O Yes	O 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)?	O No	O Yes	O Unsure
	Do you have a parent with an elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication?	O No	O Yes	O Unsure
	Do you smoke cigarettes or use e-cigarettes?	O No	O Yes	O Unsure
Oral health	Does your primary water source contain fluoride?	O Yes	O No	O Unsure
Sexually transmitted infections/ HIV	Have you ever had sex, including intercourse or oral sex? **IF NO, SKIP TO THE NEXT SECTION (HIV).**	O No	O Yes	O Unsure
	Are you having unprotected sex?	O No	O Yes	O Unsure
	Are you having sex with multiple partners or anonymous partners?	O No	O Yes	O Unsure
	Are you or any of your past or current sexual partners bisexual?	O No	O Yes	O Unsure
	Have you ever been treated for a sexually transmitted infection?	O No	O Yes	O Unsure
	Have any of your past or current sex partners been infected with HIV or used injection drugs?	O No	O Yes	O Unsure
	Do you trade sex for money or drugs or have sex partners who do?	O No	O Yes	O Unsure
	For males: Have you ever had sex with other males?	O No	O Yes	O Unsure
HIV	Do you now use or have you ever used injection drugs?	O No	O Yes	O Unsure
Tuberculosis	Are you infected with HIV?	O No	O Yes	O 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)?	O No	O Yes	O Unsure
	Have you had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	O No	O Yes	O Unsure
Vision	Do you have concerns about your vision?	O No	O Yes	O Unsure
	Have you ever failed a school vision screening test?	O No	O Yes	O Unsure
	Do you have trouble with near or far vision?	O No	O Yes	O Unsure
	Do you tend to squint?	O No	O Yes	O 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?	O Yes	O Sometimes	O No
Do you feel safe at school and getting to and from school?	O Yes	O Sometimes	O No
Have you been bullied in person, on the Internet, or through social media?	O No	O Sometimes	O Yes
Do you have ways that help you deal with feeling angry?	O Yes	O Sometimes	O No
Have you been in a fight in the past 12 months?	O No	O Sometimes	O Yes

PATIENT NAME: _____ DATE: _____

Please print.

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?	O No	O Sometimes	O Yes
Do you belong to a gang or know anyone in a gang?	O No	O Sometimes	O Yes
Have you ever been touched in a sexual way that made you feel uncomfortable?	O No	O Sometimes	O Yes
Have you ever been forced or pressured to do something sexual you didn't want to do?	O No	O Sometimes	O Yes
Have you ever been in a relationship with someone who threatened or hurt you?	O No	O Sometimes	O 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?	O No	O Sometimes	O Yes
Alcohol and Drugs			
Is there anyone in your life whose tobacco, alcohol, or drug use concerns you?	O No	O Sometimes	O Yes
Connectedness With Family and Peers			
Do you get along with your family?	O Yes	O Sometimes	O No
Does your family do things together?	O Yes	O Sometimes	O No
Do you follow your family rules and limits?	O Yes	O Sometimes	O No
Do you get along with your friends and others at school?	O Yes	O Sometimes	O No
Connectedness With Community			
Do you have interests outside of school?	O Yes	O Sometimes	O No
Do you do things you are good at or that you are proud of?	O Yes	O Sometimes	O No
School Performance			
Have you missed more than 2 days of school in any month?	O No	O Sometimes	O Yes
Are you doing well in school?	O Yes	O Sometimes	O No
Are you having any problems in school?	O No	O Sometimes	O Yes
Do you have plans for what you will do after high school?	O Yes	O Sometimes	O No
Coping With Stress and Decision-making			
Do you have ways to deal with stress?	O Yes	O Sometimes	O No
Do you worry or feel stressed out much of the time?	O No	O Sometimes	O Yes

YOUR DAILY LIFE

Healthy Teeth			
Do you brush your teeth twice a day?	O Yes	O Sometimes	O No
Do you floss once a day?	O Yes	O Sometimes	O No
Do you see the dentist twice a year?	O Yes	O Sometimes	O No
Do you chew gum or tobacco?	O No	O Sometimes	O Yes
If you play contact sports, do you wear a mouth guard?	O Yes	O Sometimes	O No
Body Image			
Do you have any concerns about your weight?	O No	O Sometimes	O Yes
Are you currently doing anything to try to gain or lose weight?	O No	O Sometimes	O Yes
Have you ever been teased because of your weight?	O No	O Sometimes	O Yes
Healthy Eating			
Do you have access to healthy food options?	O Yes	O Sometimes	O No
Do you eat fruits and vegetables every day?	O Yes	O Sometimes	O No
Do you have milk, yogurt, cheese, or other foods that contain calcium every day?	O Yes	O Sometimes	O No
Do you drink juice, soda, sports drinks, or energy drinks?	O No	O Sometimes	O Yes

PATIENT NAME: _____ DATE: _____

Please print.

15 THROUGH 17 YEAR VISITS FOR PATIENTS

YOUR DAILY LIFE (*CONTINUED*)

Healthy Eating (*continued*)			
Do you ever skip meals?	○ No	○ Sometimes	○ Yes
Do you eat meals together with your family?	○ Yes	○ Sometimes	○ 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.	○ Yes	○ Sometimes	○ 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?	○ Yes	○ Sometimes	○ No
Do you have trouble sleeping at night or waking up in the morning?	○ No	○ Sometimes	○ Yes

YOUR EMOTIONAL WELL-BEING

Mood and Mental Health			
Do you harm yourself, such as by cutting, hitting, or pinching yourself?	○ No	○ Sometimes	○ Yes
Sexuality			
Have you talked with your parents about dating and sex?	○ Yes	○ Sometimes	○ No
Do you have any questions about your gender identity?	○ No	○ Sometimes	○ Yes

HEALTHY BEHAVIOR CHOICES

Romantic Relationships and Sexual Activity				
If you have been in romantic relationships, have you always felt safe and respected?	○ NA	○ Yes	○ Sometimes	○ No
Have you ever had sex, including oral, vaginal, or anal sex? *If no, skip to the next section.*		○ No	○ Sometimes	○ Yes
Are you currently having sex, including oral sex, with anyone?		○ No	○ Sometimes	○ Yes
Have you had multiple partners in the past year?		○ No	○ Sometimes	○ Yes
Do you and your partner use condoms every time?		○ Yes	○ Sometimes	○ No
Do you and your partner always use another form of birth control along with a condom?		○ Yes	○ Sometimes	○ No
Are you aware of emergency contraception?		○ Yes	○ Sometimes	○ No
Tobacco, E-cigarettes, Alcohol, and Prescription or Street Drugs				
Have you ever smoked cigarettes or used e-cigarettes?		○ No	○ Sometimes	○ Yes
Have you ever drunk alcohol?		○ No	○ Sometimes	○ Yes
Have you ever used drugs, including marijuana or street drugs?		○ No	○ Sometimes	○ Yes
Have you ever taken prescription drugs that were not given to you for a medical condition?		○ No	○ Sometimes	○ Yes
Acoustic Trauma				
Do you use earplugs or sound-canceling headphones to protect your hearing around loud noises or at concerts?		○ Yes	○ Sometimes	○ No
Do you often listen to loud music?		○ No	○ Sometimes	○ Yes

STAYING SAFE

Seat Belt and Helmet Use				
Do you always wear a lap and shoulder seat belt?		○ Yes	○ Sometimes	○ No
Do you always wear a helmet to protect your head when you are biking, skateboarding, or skating?		○ Yes	○ Sometimes	○ No
Do you always wear a life jacket when you do water sports?		○ Yes	○ Sometimes	○ No
If you have started driving, do you follow the safety rules for young drivers?		○ Yes	○ Sometimes	○ No
Do you have someone you can call for a ride if you feel unsafe driving yourself or riding with someone else?	○ NA	○ Yes	○ Sometimes	○ No

PATIENT NAME: _____ DATE: _____

Please print.

15 THROUGH 17 YEAR VISITS FOR PATIENTS

STAYING SAFE (*CONTINUED*)

Sun Protection				
Do you use sunscreen?		O Yes	O Sometimes	O No
Do you visit tanning parlors?		O No	O Sometimes	O Yes
Gun Safety				
Have you ever carried a gun or knife (even for self-protection)?		O No	O Sometimes	O Yes
If there is a gun in your home, do you know how to get hold of it?	O NA	O No	O Sometimes	O 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®

CLEAR FORM

PATIENT NAME: _____ DATE: _____

Please print.

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.

PATIENT NAME: _____ DATE: _____

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

PATIENT NAME: _____ DATE: _____

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

YOUR GROWING AND CHANGING TEEN

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

PATIENT NAME: _____ DATE: _____

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?	O Yes	O Sometimes	O No
Have you talked with your teen about his sexuality?	O Yes	O Sometimes	O No
Do you have house rules about curfews, parties, dating, and friends?	O Yes	O Sometimes	O No
Do you know where your teen's friends are and what they're doing?	O Yes	O Sometimes	O No

HEALTHY BEHAVIOR CHOICES

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

SAFETY

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

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®