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
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.

- ☐ 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.

18 THROUGH 21 YEAR VISITS

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
	Do you or 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
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	Have you ever failed a school vision screening test?	O No	O Yes	O Unsure
	Do you have concerns about your vision?	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			
Do you get along with the people you live with?	O Yes	O Sometimes	O No
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
Do you know anyone in a gang?	O No	O Sometimes	O Yes
Do you belong to a gang?	O No	O Sometimes	O Yes

PATIENT NAME: _____ DATE: _____

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?	O No	O Sometimes	O Yes
Have you ever been touched in a sexual way against your wishes or without your consent?	O No	O Sometimes	O Yes
Have you ever been forced to have sexual intercourse?	O No	O Sometimes	O Yes
Have you been in a relationship with a person who threatens you physically or hurts you?	O No	O Sometimes	O Yes
Do you feel threatened by anyone?	O No	O Sometimes	O Yes
Are you worried that you might ever hurt someone else?	O No	O Sometimes	O Yes
Living Situation and Food Security			
Do you feel safe in your current living situation?	O Yes	O Sometimes	O No
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
Tobacco, E-cigarettes, 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 have a close friend?	O Yes	O Sometimes	O No
Do you get along with members of your family?	O Yes	O Sometimes	O No
Connectedness With Community			
Do you have activities you like to do after school or work or on the weekends?	O Yes	O Sometimes	O No
Do you help others out at home, at school, or in your community?	O Yes	O Sometimes	O No
School Performance			
Have you graduated from high school or completed a GED?	O Yes	O Sometimes	O No
Do you have plans for work or school?	O Yes	O Sometimes	O No
Coping With Stress and Decision-making			
Do you feel really stressed out all the time?	O No	O Sometimes	O Yes
Do you have strategies to reduce or relieve your stress?	O Yes	O Sometimes	O No

YOUR DAILY LIFE

Healthy Teeth			
Do you brush your teeth twice a day?	O Yes	O Sometimes	O No
Do you floss your teeth once a day?	O Yes	O Sometimes	O No
Do you see the dentist regularly?	O Yes	O Sometimes	O No
Do you have trouble accessing dental care?	O No	O Sometimes	O Yes
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
Healthy Eating			
Do you have access to healthy food options at home and school?	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
Do you ever skip meals?	O No	O Sometimes	O Yes
Do you eat meals together with your family?	O Yes	O Sometimes	O No

PATIENT NAME: _____ DATE: _____

Please print.

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.	O Yes	O Sometimes	O No
How much time do you spend on screen time unrelated to work or school each day?	_____ hours		
Do you have a regular bedtime?	O Yes	O Sometimes	O No
Do you have trouble getting to sleep at night or waking up in the morning?	O No	O Sometimes	O Yes
Transition to Adult Health Care			
Do you feel confident about your ability to begin seeing an adult doctor?	O Yes	O Sometimes	O No
Do you have health insurance coverage?	O Yes	O Sometimes	O No
Do you know your medical conditions, medications, allergies, and family history?	O Yes	O Sometimes	O No

EMOTIONAL WELL-BEING

Mood and Mental Health			
Do you harm yourself, such as by cutting, hitting, or pinching yourself?	O No	O Sometimes	O Yes
Sexuality			
Do you have any questions about your gender identity?	O No	O Sometimes	O Yes

HEALTHY BEHAVIOR CHOICES

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

STAYING SAFE

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

PATIENT NAME: _____ DATE: _____

Please print.

18 THROUGH 21 YEAR VISITS

STAYING SAFE (*CONTINUED*)

Sun Protection			
Do you use sunscreen?	○ Yes	○ Sometimes	○ No
Do you visit tanning parlors?	○ No	○ Sometimes	○ Yes
Gun Safety			
Do you have access to guns?	○ No	○ Sometimes	○ Yes
Have you carried a weapon to school or work?	○ No	○ Sometimes	○ 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®