American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
11 THROUGH 14 YEAR VISITS FOR PARENTS

To provide you and your child 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 CHILD AND FAMILY.

What excites or delights you most about your child?

Does your child have 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 child’s relatives developed new medical problems since your last visit?  ○ No  ○ Yes  ○ Unsure If yes or unsure, please describe:

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

YOUR GROWING AND DEVELOPING CHILD

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

☐ My child does things that help her have a healthy lifestyle, such as eating healthy foods, being physically active, and keeping herself safe.

☐ My child has at least one adult in his life who cares about him and knows he can go to if he needs help.

☐ My child has at least one friend or a group of friends who she feels comfortable around.

☐ My child helps others by himself or by working with a group in school, a faith-based organization, or the community.

☐ My child is able to bounce back when things don’t go her way.

☐ My child feels hopeful and self-confident.

☐ My child is becoming more independent and making more decisions on his own as he gets older.

PATIENT NAME: ____________________________  DATE: ____________

American Academy of Pediatrics  |  Bright Futures  |  https://brightfutures.aap.org
# RISK ASSESSMENT

<table>
<thead>
<tr>
<th>Anemia</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?</td>
<td>O Yes</td>
<td>O No</td>
<td>O Unsure</td>
</tr>
<tr>
<td>Has your child ever been diagnosed with iron deficiency anemia?</td>
<td>O No</td>
<td>O Yes</td>
<td>O Unsure</td>
</tr>
<tr>
<td>Does your family ever struggle to put food on the table?</td>
<td>O No</td>
<td>O Yes</td>
<td>O Unsure</td>
</tr>
<tr>
<td><strong>If your child is female,</strong> does she have excessive menstrual bleeding or other blood loss?</td>
<td>O No</td>
<td>O Yes</td>
<td>O Unsure</td>
</tr>
<tr>
<td><strong>If your child is female,</strong> does her period last more than 5 days?</td>
<td>O No</td>
<td>O Yes</td>
<td>O Unsure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dyslipidemia</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Does your child have parents, grandparents, or aunts or uncles who have had a stroke or heart problem before age 55 (males) or 65 (females)?</td>
<td>O No</td>
<td>O Yes</td>
<td>O Unsure</td>
</tr>
<tr>
<td>Does your child have a parent with an elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication?</td>
<td>O No</td>
<td>O Yes</td>
<td>O Unsure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hearing</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Do you have concerns about how your child hears?</td>
<td>O No</td>
<td>O Yes</td>
<td>O Unsure</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Oral health</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Does your child's primary water source contain fluoride?</td>
<td>O Yes</td>
<td>O No</td>
<td>O Unsure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexually transmitted infections/ HIV</th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Adolescents who are sexually active are at risk of sexually transmitted infection, including HIV. Adolescents who use injection drugs are at risk of HIV. Are you concerned that your young adolescent might be at risk?</td>
<td>O No</td>
<td>O Yes</td>
<td>O Unsure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tuberculosis</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Is your child infected with HIV?</td>
<td>O No</td>
<td>O Yes</td>
<td>O Unsure</td>
</tr>
<tr>
<td>Was your child 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)?</td>
<td>O No</td>
<td>O Yes</td>
<td>O Unsure</td>
</tr>
<tr>
<td>Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?</td>
<td>O No</td>
<td>O Yes</td>
<td>O Unsure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vision</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have concerns about how your child sees?</td>
<td>O No</td>
<td>O Yes</td>
<td>O Unsure</td>
</tr>
<tr>
<td>Does your child have trouble with near or far vision?</td>
<td>O No</td>
<td>O Yes</td>
<td>O Unsure</td>
</tr>
<tr>
<td>Has your child ever failed a school vision screening test?</td>
<td>O No</td>
<td>O Yes</td>
<td>O Unsure</td>
</tr>
<tr>
<td>Does your child tend to squint?</td>
<td>O No</td>
<td>O Yes</td>
<td>O Unsure</td>
</tr>
</tbody>
</table>

# ANTICIPATORY GUIDANCE

**How are things going for you, your child, and your family?**

**YOUR FAMILY’S HEALTH AND WELL-BEING**

<table>
<thead>
<tr>
<th>Interpersonal Violence (Fighting and Bullying)</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there frequent reports of violence in your community or school?</td>
<td>O No</td>
<td>O Sometimes</td>
<td>O Yes</td>
</tr>
<tr>
<td>Is your child involved in any of the violence?</td>
<td>O No</td>
<td>O Sometimes</td>
<td>O Yes</td>
</tr>
<tr>
<td>Do you think your child is safe in the neighborhood?</td>
<td>O Yes</td>
<td>O Sometimes</td>
<td>O No</td>
</tr>
<tr>
<td>Has your child ever been injured in a fight?</td>
<td>O No</td>
<td>O Sometimes</td>
<td>O Yes</td>
</tr>
<tr>
<td>Has your child been bullied or hurt by others?</td>
<td>O No</td>
<td>O Sometimes</td>
<td>O Yes</td>
</tr>
<tr>
<td>Has your child bullied or been aggressive toward others?</td>
<td>O No</td>
<td>O Sometimes</td>
<td>O Yes</td>
</tr>
<tr>
<td>Have you talked with your child about violence in dating situations and how to be safe?</td>
<td>O Yes</td>
<td>O Sometimes</td>
<td>O No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Living Situation and Food Security</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have concerns about your living situation?</td>
<td>O No</td>
<td>O Sometimes</td>
<td>O Yes</td>
</tr>
<tr>
<td>Do you have enough heat, hot water, and electricity?</td>
<td>O Yes</td>
<td>O Sometimes</td>
<td>O No</td>
</tr>
<tr>
<td>Do you have appliances that work?</td>
<td>O Yes</td>
<td>O Sometimes</td>
<td>O No</td>
</tr>
<tr>
<td>Do you have problems with bugs, rodents, or peeling paint or plaster?</td>
<td>O No</td>
<td>O Sometimes</td>
<td>O Yes</td>
</tr>
<tr>
<td>In the past 12 months, did you worry that your food would run out before you got money to buy more?</td>
<td>O No</td>
<td>O Sometimes</td>
<td>O Yes</td>
</tr>
<tr>
<td>In the past 12 months, did the food you bought not last, and you did not have money to buy more?</td>
<td>O No</td>
<td>O Sometimes</td>
<td>O Yes</td>
</tr>
</tbody>
</table>
### Alcohol and Drugs
Is there anyone in your child’s life whose alcohol or drug use concerns you?  
- ☐ No  
- ☐ Sometimes  
- ☐ Yes

### Connectedness With Family and Peers
Does your family get along well with each other?  
- ☐ Yes  
- ☐ Sometimes  
- ☐ No

Do you take time to talk with your child every day?  
- ☐ Yes  
- ☐ Sometimes  
- ☐ No

Does your family do things together?  
- ☐ Yes  
- ☐ Sometimes  
- ☐ No

Does your child have chores or responsibilities at home?  
- ☐ Yes  
- ☐ Sometimes  
- ☐ No

Do you have clear rules and expectations for your child?  
- ☐ Yes  
- ☐ Sometimes  
- ☐ No

Do you let your child know when he does something good?  
- ☐ Yes  
- ☐ Sometimes  
- ☐ No

### Connectedness With Community
Does your child have interests outside of school?  
- ☐ Yes  
- ☐ Sometimes  
- ☐ No

Does your child help others at home, in school, or in your community?  
- ☐ Yes  
- ☐ Sometimes  
- ☐ No

### School Performance
Is your child getting to school on time?  
- ☐ Yes  
- ☐ Sometimes  
- ☐ No

Is your child having any problems at school?  
- ☐ No  
- ☐ Sometimes  
- ☐ Yes

Does your child complete homework on time?  
- ☐ Yes  
- ☐ Sometimes  
- ☐ No

Has your child missed more than 2 days of school in any month?  
- ☐ No  
- ☐ Sometimes  
- ☐ Yes

### Coping With Stress and Decision-making
Does your child worry too much or appear overly anxious?  
- ☐ No  
- ☐ Sometimes  
- ☐ Yes

Have you discussed ways to deal with stress?  
- ☐ Yes  
- ☐ Sometimes  
- ☐ No

Do you help your child make decisions and solve problems?  
- ☐ Yes  
- ☐ Sometimes  
- ☐ No

### Healthy Teeth
Does your child see the dentist regularly?  
- ☐ Yes  
- ☐ Sometimes  
- ☐ No

Do you have trouble getting dental care?  
- ☐ No  
- ☐ Sometimes  
- ☐ Yes

### Body Image
Do you have any concerns about your child’s nutrition, weight, or physical activity?  
- ☐ No  
- ☐ Sometimes  
- ☐ Yes

Does your child talk about getting fat or dieting to lose weight?  
- ☐ No  
- ☐ Sometimes  
- ☐ Yes

### Healthy Eating
Do you think your child eats healthy foods?  
- ☐ Yes  
- ☐ Sometimes  
- ☐ No

Do you have any difficulty getting healthy food for your family?  
- ☐ No  
- ☐ Sometimes  
- ☐ Yes

Do you have any concerns about your child’s eating habits or nutrition?  
- ☐ No  
- ☐ Sometimes  
- ☐ Yes

Do you eat meals together as a family?  
- ☐ Yes  
- ☐ Sometimes  
- ☐ No

### Physical Activity and Sleep
Is your child physically active at least 1 hour a day? This includes running, playing sports, or doing physically active things with friends.  
- ☐ Yes  
- ☐ Sometimes  
- ☐ No

Are there opportunities to safely play outside in your neighborhood?  
- ☐ Yes  
- ☐ Sometimes  
- ☐ No

Do you and your child participate in physical activities together?  
- ☐ Yes  
- ☐ Sometimes  
- ☐ No

How much time does your child spend on recreational screen time each day?  
- _____ hours

Does your child have a TV, computer, tablet, or smartphone in his bedroom?  
- ☐ No  
- ☐ Sometimes  
- ☐ Yes

Do you have rules about screen time for your child?  
- ☐ Yes  
- ☐ Sometimes  
- ☐ No

Has your family made a family media use plan to help everyone balance time spent on media with other family and personal activities?  
- ☐ Yes  
- ☐ Sometimes  
- ☐ No

Does your child have a regular bedtime?  
- ☐ Yes  
- ☐ Sometimes  
- ☐ No
### Mood and Mental Health

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Sometimes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is your child frequently irritable?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Have you noticed any changes in your child’s weight or sleep habits?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Do you and your child often have conflicts about what your culture expects for her behavior and how her friends behave?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Do you have any concerns about your child’s emotional health, such as being frequently sad or depressed?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

### Sexuality

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Sometimes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you and your child talked about how his body will change during puberty?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Do you have house rules about curfews, dating, and friends?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

### Sexual Activity

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Sometimes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you and your child talked about sex?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Have you talked about ways to deal with any pressures to have sex?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

### Substance Use

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Sometimes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you talked with your child about alcohol and drug use?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Do you know your child’s friends?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Do you know where your child is and what she does after school and on the weekends?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Do you have consequences for your child if you discover he is using tobacco, alcohol, or drugs?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>To your knowledge, is your child currently using alcohol or drugs, or has she used them in the past?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

### Acoustic Trauma

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Sometimes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your child often listen to loud music?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

### Seat Belt and Helmet Use

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Sometimes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you always wear a lap and shoulder seat belt and bicycle helmet?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Do you insist your child wears a lap and shoulder seat belt when in a car?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Do you insist that your child use a life jacket when he does water sports?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

### Sun Protection

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Sometimes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your child use sunscreen?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

### Gun Safety

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Sometimes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a gun in your home or the homes where your child visits?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>If yes, is the gun unloaded and locked up?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>If yes, is the ammunition stored and locked up separately from the gun?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Have you talked with your child about gun safety?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

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. The American Academy of Pediatrics (AAP) does not review or endorse any modifications made to this questionnaire and in no event shall the AAP be liable for any such changes. © 2019 American Academy of Pediatrics. All rights reserved.
American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
11 THROUGH 14 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 (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.
# 11 THROUGH 14 YEAR VISITS FOR PATIENTS

## RISK ASSESSMENT

### Anemia
- Does your diet include iron-rich foods, such as meat, iron-fortified cereals, or beans? [Yes] [No] [Unsure]
- Do you eat a vegetarian diet (do not eat red meat, chicken, fish, or seafood)? [No] [Yes] [Unsure]
- If you are a vegetarian (do not eat red meat, chicken, fish, or seafood), do you take an iron supplement? [Yes] [No] [Unsure]

### Dyslipidemia
- Do you smoke cigarettes or use e-cigarettes? [No] [Yes] [Unsure]

### Vision
- Do you have concerns about how well you see? [No] [Yes] [Unsure]

## ANTICIPATORY GUIDANCE

### How are things going for you and your family?

#### HOW YOU ARE DOING

<table>
<thead>
<tr>
<th>Interpersonal Violence (Fighting and Bullying)</th>
<th>[No] [Sometimes] [Yes]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you been part of a gang or a group that has gotten or could get into trouble?</td>
<td>[No] [Sometimes] [Yes]</td>
</tr>
<tr>
<td>Have you been in a fight in the past 6 months?</td>
<td>[No] [Sometimes] [Yes]</td>
</tr>
<tr>
<td>Do you know anyone in a gang?</td>
<td>[No] [Sometimes] [Yes]</td>
</tr>
<tr>
<td>Do you have ways that help you deal with feeling angry?</td>
<td>[Yes] [Sometimes] [No]</td>
</tr>
<tr>
<td>Do you feel safe at home?</td>
<td>[Yes] [Sometimes] [No]</td>
</tr>
<tr>
<td>Have you ever been bullied in person, on the Internet, or through social media?</td>
<td>[No] [Sometimes] [Yes]</td>
</tr>
<tr>
<td>Have you been in a relationship with a person who threatened you physically or hurt you?</td>
<td>[No] [Sometimes] [Yes]</td>
</tr>
<tr>
<td>Have you ever been touched in a way that made you feel uncomfortable?</td>
<td>[No] [Sometimes] [Yes]</td>
</tr>
<tr>
<td>Has anyone touched your private parts without your agreement or against your wishes?</td>
<td>[No] [Sometimes] [Yes]</td>
</tr>
<tr>
<td>Have you ever been forced or pressured to do something sexually that you didn’t want to do?</td>
<td>[No] [Sometimes] [Yes]</td>
</tr>
</tbody>
</table>

### Connectedness With Family and Peers
- Do you spend time talking with your parents every day? [Yes] [Sometimes] [No]
- Do your parents praise you when you do something good or learn something new? [Yes] [Sometimes] [No]
- Do you get along with your family? [Yes] [Sometimes] [No]
- Does your family do things together? [Yes] [Sometimes] [No]
- Do you have an adult you feel connected to? [Yes] [Sometimes] [No]
- Do you have rules at home and know what happens when you break the rules? [Yes] [Sometimes] [No]

### Connectedness With Community
- Do you have activities or things you like to do after school or on the weekends? [Yes] [Sometimes] [No]
- Do you help others at home, in school, or in your community? [Yes] [Sometimes] [No]

### School Performance
- Are you doing well at school? [Yes] [Sometimes] [No]
- Do you have things you enjoy doing at school? [Yes] [Sometimes] [No]
- Are you having any problems in school? Are there things you need help figuring out? [No] [Sometimes] [Yes]
- Do you get extra help or support in any subjects at school? [No] [Sometimes] [Yes]

### Coping With Stress and Decision-making
- Do you worry a lot or feel overly stressed out? [No] [Sometimes] [Yes]
- Do you have things you do to feel better when you are stressed? [Yes] [Sometimes] [No]
### YOUR GROWING AND CHANGING BODY

#### Healthy Teeth
- Do you brush your teeth twice a day? [ ] Yes [ ] Sometimes [ ] No
- Do you see the dentist twice a year? [ ] Yes [ ] Sometimes [ ] No
- If you play contact sports, do you wear a mouth guard? [ ] Yes [ ] Sometimes [ ] No

#### Body Image
- Do you have any concerns about your weight? [ ] No [ ] Sometimes [ ] Yes
- Are you teased about your weight? [ ] No [ ] Sometimes [ ] Yes
- Are you currently doing anything to try to gain or lose weight? [ ] No [ ] Sometimes [ ] Yes

#### Healthy Eating
- Do you have healthy food options at home and in school? [ ] Yes [ ] Sometimes [ ] No
- Do you eat fruits and vegetables every day? [ ] Yes [ ] Sometimes [ ] No
- Do you have milk, yogurt, cheese, or other foods that contain calcium every day? [ ] Yes [ ] Sometimes [ ] No
- Do you drink juice, soda, sports drinks, or energy drinks? [ ] No [ ] Sometimes [ ] Yes
- 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 a day? This includes running, playing sports, or active play 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? [ ] No [ ] Sometimes [ ] 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? [ ] No [ ] Sometimes [ ] Yes
- Have you talked with your parents about dating and sex? [ ] Yes [ ] Sometimes [ ] No
- Do you have questions or concerns about how your body is changing (puberty)? [ ] No [ ] Sometimes [ ] Yes
- **For girls:** Have you started your period? [ ] No [ ] Sometimes [ ] Yes
- **For girls:** If yes, do you have any concerns about your period (such as not regular, heavy bleeding, or bad cramping)? [ ] No [ ] Sometimes [ ] Yes

### HEALTHY BEHAVIOR CHOICES

#### Romantic Relationships
- Have you ever been in a romantic relationship? [ ] No [ ] Sometimes [ ] Yes
- If yes, have you always felt safe and respected? [ ] 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 been offered any drugs? [ ] 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

## Seatbelt and Helmet Use

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>Sometimes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you always wear a lap and shoulder seat belt?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Do you always wear a helmet to protect your head when you are biking, skateboarding, or skating?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Do you always wear a life jacket when you do water sports?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

## Sun Protection

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>Sometimes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you use sunscreen?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Do you visit tanning parlors?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

## Substance Use and Riding in a Vehicle

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>Sometimes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever ridden in a car with someone who has been drinking or using drugs?</td>
<td>O No</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Do you have someone you can call for a ride if you feel unsafe riding with someone?</td>
<td>O Yes</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

## Gun Safety

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>Sometimes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever carried a gun or knife (even for self-protection)?</td>
<td>O No</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>If there is a gun in your home, do you know how to get hold of it?</td>
<td>O NA</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

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. The American Academy of Pediatrics (AAP) does not review or endorse any modifications made to this questionnaire and in no event shall the AAP be liable for any such changes. © 2019 American Academy of Pediatrics. All rights reserved.
# Well Adolescent | 11 Through 14 Year Visits

<table>
<thead>
<tr>
<th>Accompanied By:</th>
<th>Preferred Language:</th>
<th>Date/Time:</th>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Weight (%)</th>
<th>Height (%)</th>
<th>BMI (%)</th>
<th>BP (%)</th>
<th>ID Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Vitals (if indicated):</th>
<th>Temp</th>
<th>HR</th>
<th>Resp Rate</th>
<th>SpO₂</th>
<th>Birth Date:</th>
<th>Age:</th>
<th>Sex:</th>
<th>M</th>
<th>F</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tbody>
</table>

**HISTORY**

**Concerns and Questions:** [ ] None

**Interval History:** [ ] None

**Medical History:** [ ] Adolescent has special health care needs.

- Areas reviewed and updated as needed
- [ ] Past Medical History (See Initial History Questionnaire.)
- [ ] Surgical History (See Initial History Questionnaire.)
- [ ] Problem List (See Problem List.)

**Medications:** [ ] None

[ ] Reviewed and updated (See Medication Record.)

**Allergies:** [ ] No known drug allergies

**Nutrition:** [ ] Daily fruits and vegetables

- Iron source: 
- Calcium source: 
- Comments: 

**Body image:** [ ] No concerns

**Attempting to gain or lose weight:** [ ] No [ ] Yes

**Females:** Menarche age: _____  Regular: [ ] Yes [ ] No: 

**Mood:** [ ] No concerns

**Dental Home:** [ ] No [ ] Yes: ________  [ ] Regular visits

**Sleep:** [ ] No concerns

**Physical Activity:**

- Exercise (60 min/d): [ ] Yes [ ] No: ________

**Screen time:** h/d: _____

**Family media use plan discussed:** [ ] Yes [ ] No

**School:** Grade: _____  IEP/504/behavior plan: [ ] Yes [ ] No [ ] NA

**Performance:** [ ] NL

**Parent/teacher concerns:** [ ] None

**Activities:**

**Tobacco, alcohol, and drug use:** [ ] None

**Sexual Orientation/Gender Identity:**

**Sexual Activity:** [ ] Denies

**Mood:** [ ] No concerns

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### Physical Examination

*Well-appearing adolescent. Normal BMI and BP for age.*

#### Constitutional:
- Eyes:
- Head, Ears, Nose, and Throat:
- Cardiovascular:
- Respiratory:
- Gastrointestinal:
- Genitourinary:
- Musculoskeletal:
- Skin:
- Neurological:
- Other:

**System Examined**

**Focus Area**

#### Social and Family History

Areas reviewed and updated as needed:
- Social History
- Family History

Changes since last visit:

Smoking household:
- No
- Yes:

Firearms in home:
- No
- Yes:

Adolescent lives with:

Relationships with parents/siblings:

#### Review of Systems

*Bold = Focus area for this Bright Futures Visit*

<table>
<thead>
<tr>
<th>Constitutional</th>
<th>Respiratory</th>
<th>Gastrointestinal</th>
<th>Neurological</th>
<th>Skin</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head, Ears, Nose, and Throat:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular:</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

#### Development

- Forms caring, supportive relationships with family members, other adults, and peers
- Engages in positive way with life of the community

**Sexual Maturity Rating**

- Female: Breast development SMR, pubic hair SMR
- Male: Testicular development SMR, pubic hair SMR
- Musculoskeletal: Spine straight without deformities. No significant scoliosis. Full range of motion.

- Skin: Warm and well perfused. No acanthosis nigricans. No signs of cutting or other self-injury. No lesions or birthmarks.
Well Adolescent | 11 Through 14 Year Visits

Name: ________________________________

ASSESSMENT

☐ Well adolescent  ☐ Normal BMI percentile for age  ☐ Normal BP for age

ANTICIPATORY GUIDANCE

✓ Discussed and/or handout given

☐ SOCIAL DETERMINANTS OF HEALTH
  - Interpersonal violence
  - Living situation and food security
  - Family substance use
  - Connectedness with family, peers, and community
  - School performance
  - Coping with stress and decision-making

☐ DEVELOPMENT AND MENTAL HEALTH
  - Family rules and routines, concern for others, and respect for others
  - Patience and control over anger

☐ PHYSICAL GROWTH AND DEVELOPMENT
  - Oral health
  - Body image
  - Healthy eating
  - Physical activity and sleep

☐ EMOTIONAL WELL-BEING
  - Mood regulation and mental health
  - Sexuality

☐ RISK REDUCTION
  - Pregnancy and sexually transmitted infections
  - Tobacco, e-cigarettes, alcohol, and prescription or street drugs
  - Acoustic trauma

☐ SAFETY
  - Seat belt and helmet use
  - Sun protection
  - Substance use and riding in a vehicle
  - Firearm safety

PLAN

Immunizations: ☐ Vaccine Administration Record reviewed  ☐ Administered today: ________________________________  ☐ Up-to-date for age

Universal Screening:

☐ Depression screening (annual ages 12–14): Screening tool used: ________________________________ Result: ☐ Neg ☐ Pos: ________________________________

☐ Tobacco, alcohol, and drug use (annual ages 12–14): Screening tool used: ________________________________ Result: ☐ Neg ☐ Pos: ________________________________

☐ Dyslipidemia (once between 9 and 11): ☐ Completed age: _____ Result: ☐ Within reference range ☐ Abnormal: ______ Follow-up: __________

☐ Hearing (once between 11 and 14): ☐ Completed age: _____ Result: ☐ Normal hearing BL ☐ Abnormal: ______ Follow-up: __________

☐ Vision (once age 12): ☐ Result: ☐ Normal vision for age ☐ Abnormal: ______ Follow-up: __________

Selective Screening (based on risk assessment) (See Previsit Questionnaire):

☐ Anemia  ☐ Dyslipidemia  ☐ Hearing  ☐ HIV  ☐ Sexually transmitted infections  ☐ Tuberculosis  ☐ Vision

Comments/results:

Follow-up:

☐ Routine follow-up in 1 year  ☐ Next visit: ____  ☐ Referral to: ________________________________

PRINT NAME.

SIGNATURE

Provider 1

Provider 2

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HOW YOUR FAMILY IS DOING

- Encourage your child to be part of family decisions. Give your child the chance to make more of her own decisions as she grows older.
- Encourage your child to think through problems with your support.
- Help your child find activities she is really interested in, besides schoolwork.
- Help your child find and try activities that help others.
- Help your child deal with conflict.
- Help your child figure out nonviolent ways to handle anger or fear.
- If you are worried about your living or food situation, talk with us. Community agencies and programs such as SNAP can also provide information and assistance.

YOUR CHILD’S FEELINGS

- Find ways to spend time with your child.
- If you are concerned that your child is sad, depressed, nervous, irritable, hopeless, or angry, let us know.
- Talk with your child about how his body is changing during puberty.
- If you have questions about your child’s sexual development, you can always talk with us.

YOUR GROWING AND CHANGING CHILD

- Help your child get to the dentist twice a year.
- Give your child a fluoride supplement if the dentist recommends it.
- Encourage your child to brush her teeth twice a day and floss once a day.
- Praise your child when she does something well, not just when she looks good.
- Support a healthy body weight and help your child be a healthy eater.
  - Provide healthy foods.
  - Eat together as a family.
  - Be a role model.
- Help your child get enough calcium with low-fat or fat-free milk, low-fat yogurt, and cheese.
- Encourage your child to get at least 1 hour of physical activity every day. Make sure she uses helmets and other safety gear.
- Consider making a family media use plan. Make rules for media use and balance your child’s time for physical activities and other activities.
- Check in with your child’s teacher about grades. Attend back-to-school events, parent-teacher conferences, and other school activities if possible.
- Talk with your child as she takes over responsibility for schoolwork.
- Help your child with organizing time, if she needs it.
- Encourage daily reading.

HEALTHY BEHAVIOR CHOICES

- Help your child find fun, safe things to do.
- Make sure your child knows how you feel about alcohol and drug use.
- Know your child’s friends and their parents. Be aware of where your child is and what he is doing at all times.
- Lock your liquor in a cabinet.
- Store prescription medications in a locked cabinet.
- Talk with your child about relationships, sex, and values.
- If you are uncomfortable talking about puberty or sexual pressures with your child, please ask us or others you trust for reliable information that can help.
- Use clear and consistent rules and discipline with your child.
- Be a role model.

Helpful Resource: Family Media Use Plan: www.healthychildren.org/MediaUsePlan
11 THROUGH 14 YEAR VISITS—PARENT

SAFETY

- Make sure everyone always wears a lap and shoulder seat belt in the car.
- Provide a properly fitting helmet and safety gear for biking, skating, in-line skating, skiing, snowmobiling, and horseback riding.
- Use a hat, sun protection clothing, and sunscreen with SPF of 15 or higher on her exposed skin. Limit time outside when the sun is strongest (11:00 am–3:00 pm).
- Don’t allow your child to ride ATVs.
- Make sure your child knows how to get help if she feels unsafe.
- If it is necessary to keep a gun in your home, store it unloaded and locked with the ammunition locked separately from the gun.

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HOW YOU ARE DOING

- Enjoy spending time with your family. Look for ways to help out at home.
- Follow your family’s rules.
- Try to be responsible for your schoolwork.
- If you need help getting organized, ask your parents or teachers.
- Try to read every day.
- Find activities you are really interested in, such as sports or theater.
- Find activities that help others.
- Figure out ways to deal with stress in ways that work for you.
- Don’t smoke, vape, use drugs, or drink alcohol. Talk with us if you are worried about alcohol or drug use in your family.
- Always talk through problems and never use violence.
- If you get angry with someone, try to walk away.

YOUR GROWING AND CHANGING BODY

- Brush your teeth twice a day and floss once a day.
- Visit the dentist twice a year.
- Wear a mouth guard when playing sports.
- Be a healthy eater. It helps you do well in school and sports.
  - Have vegetables, fruits, lean protein, and whole grains at meals and snacks.
  - Limit fatty, sugary, salty foods that are low in nutrients, such as candy, chips, and ice cream.
  - Eat when you’re hungry. Stop when you feel satisfied.
  - Eat with your family often.
  - Eat breakfast.
- Choose water instead of soda or sports drinks.
- Aim for at least 1 hour of physical activity every day.
- Get enough sleep.

HEALTHY BEHAVIOR CHOICES

- Find fun, safe things to do.
- Talk with your parents about alcohol and drug use.
- Say “No!” to drugs, alcohol, cigarettes and e-cigarettes, and sex. Saying “No!” is OK.
- Don’t share your prescription medicines; don’t use other people’s medicines.
- Choose friends who support your decision not to use tobacco, alcohol, or drugs. Support friends who choose not to use.
- Healthy dating relationships are built on respect, concern, and doing things both of you like to do.
- Talk with your parents about relationships, sex, and values.
- Talk with your parents or another adult you trust about puberty and sexual pressures. Have a plan for how you will handle risky situations.

YOUR FEELINGS

- Be proud of yourself when you do something good.
- It’s OK to have up-and-down moods, but if you feel sad most of the time, let us know so we can help you.
- It’s important for you to have accurate information about sexuality, your physical development, and your sexual feelings toward the opposite or same sex. Ask us if you have any questions.
11 THROUGH 14 YEAR VISITS—PATIENT

STAYING SAFE

• Always wear your lap and shoulder seat belt.
• Wear protective gear, including helmets, for playing sports, biking, skating, skiing, and skateboarding.
• Always wear a life jacket when you do water sports.
• Always use sunscreen and a hat when you’re outside. Try not to be outside for too long between 11:00 am and 3:00 pm, when it’s easy to get a sunburn.
• Don’t ride ATVs.
• Don’t ride in a car with someone who has used alcohol or drugs. Call your parents or another trusted adult if you are feeling unsafe.
• Fighting and carrying weapons can be dangerous. Talk with your parents, teachers, or doctor about how to avoid these situations.

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