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.

<table>
<thead>
<tr>
<th>WHAT WOULD YOU LIKE TO TALK ABOUT TODAY?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have any concerns, questions, or problems that you would like to discuss today?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TELL US ABOUT YOURSELF:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are you most proud of about yourself?</td>
</tr>
</tbody>
</table>

| 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 |

| Do you live with anyone who smokes or spend time in places where people smoke or use e-cigarettes?  | No | Yes | Unsure |

<table>
<thead>
<tr>
<th>GROWING AND DEVELOPING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check off all the items that you feel are true for you.</td>
</tr>
<tr>
<td>□ I do things that help me have a healthy lifestyle, such as eating healthy foods, being physically active, and keeping myself safe.</td>
</tr>
<tr>
<td>□ I have at least one adult in my life who I know I can go to if I need help.</td>
</tr>
<tr>
<td>□ I have a friend or a group of friends that I feel comfortable to be around.</td>
</tr>
<tr>
<td>□ I help others.</td>
</tr>
<tr>
<td>□ I am able to bounce back when life doesn’t go my way.</td>
</tr>
<tr>
<td>□ I feel hopeful and confident.</td>
</tr>
<tr>
<td>□ I am becoming more independent and I make more of my own decisions.</td>
</tr>
</tbody>
</table>
### RISK ASSESSMENT

#### Anemia

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your diet include iron-rich foods, such as meat, iron-fortified</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>cereals, or beans?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Do you eat a vegetarian diet (do not eat red meat, chicken, fish, or</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>seafood)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you are a vegetarian (do not eat red meat, chicken, fish, or seafood), do you take an iron supplement?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Have you ever been diagnosed as having iron deficiency anemia?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Do you or your family ever struggle to put food on the table?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

**For females:**

- Have you ever been diagnosed as having iron deficiency anemia? 
  - No
  - Yes
  - Unsure

#### Dyslipidemia

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

#### Sexually transmitted infections/ HIV

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever had sex, including intercourse or oral sex? IF NO, SKIP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TO THE NEXT SECTION (HIV).</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Are you having unprotected sex?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Are you having sex with multiple partners or anonymous partners?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Are you or any of your past or current sexual partners bisexual?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Have you ever been treated for a sexually transmitted infection?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Have any of your past or current sex partners been infected with HIV or</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>used injection drugs?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you trade sex for money or drugs or have sex partners who do?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

**For males:**

- Have you ever had sex with other males? 
  - No
  - Yes
  - Unsure

#### HIV

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you now use or have you ever used injection drugs?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Are you infected with HIV?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

#### Tuberculosis

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were you or was any household member born in, or has he or she traveled</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>to, a country where tuberculosis is common (this includes countries in</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Africa, Asia, Latin America, and Eastern Europe)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had close contact with a person who has tuberculosis disease or</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>who has had a positive tuberculosis test result?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Vision

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

### ANTICIPATORY GUIDANCE

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

**HOW YOU ARE DOING**

#### Interpersonal Violence

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>Sometimes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you get along with the people you live with?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Do you have ways that help you deal with feeling angry?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Have you been in a fight in the past 12 months?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Do you know anyone in a gang?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Do you belong to a gang?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>
18 THROUGH 21 YEAR VISITS

### HOW YOU ARE DOING (CONTINUED)

#### Interpersonal Violence (continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Sometimes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever been hit, slapped, or physically hurt while on a date?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever been touched in a sexual way against your wishes or without your consent?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever been forced to have sexual intercourse?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been in a relationship with a person who threatens you physically or hurts you?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you feel threatened by anyone?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you worried that you might ever hurt someone else?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Living Situation and Food Security

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>Sometimes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you feel safe in your current living situation?</td>
<td></td>
<td></td>
<td></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></td>
<td></td>
<td></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></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Tobacco, E-cigarettes, Alcohol, and Drugs

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Sometimes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there anyone in your life whose tobacco, alcohol, or drug use concerns you?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Connectedness With Family and Peers

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>Sometimes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have a close friend?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you get along with members of your family?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Connectedness With Community

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>Sometimes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have activities you like to do after school or work or on the weekends?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you help others out at home, at school, or in your community?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### School Performance

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>Sometimes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you graduated from high school or completed a GED?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have plans for work or school?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Coping With Stress and Decision-making

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Sometimes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you feel really stressed out all the time?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have strategies to reduce or relieve your stress?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### YOUR DAILY LIFE

#### Healthy Teeth

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>Sometimes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you brush your teeth twice a day?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you floss your teeth once a day?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you see the dentist regularly?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have trouble accessing dental care?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Body Image

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Sometimes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have any concerns about your weight?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you currently doing anything to try to gain or lose weight?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Healthy Eating

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>Sometimes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have access to healthy food options at home and school?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you eat fruits and vegetables every day?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have milk, yogurt, cheese, or other foods that contain calcium every day?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you drink juice, soda, sports drinks, or energy drinks?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you ever skip meals?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you eat meals together with your family?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## 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?  
  - Yes
  - Sometimes
  - No
- How much time do you spend on screen time unrelated to work or school each day?  
  - ____ hours
- Do you have a regular bedtime?  
  - Yes
  - Sometimes
  - No
- Do you have trouble getting to sleep at night or waking up in the morning?  
  - No
  - Sometimes
  - Yes

#### Transition to Adult Health Care
- Do you feel confident about your ability to begin seeing an adult doctor?  
  - Yes
  - Sometimes
  - No
- Do you have health insurance coverage?  
  - Yes
  - Sometimes
  - No
- Do you know your medical conditions, medications, allergies, and family history?  
  - Yes
  - Sometimes
  - No

### EMOTIONAL WELL-BEING

#### Mood and Mental Health
- Do you harm yourself, such as by cutting, hitting, or pinching yourself?  
  - No
  - Sometimes
  - Yes

#### Sexuality
- 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?  
  - Yes
  - Sometimes
  - No
- Have you ever had sex, including oral, vaginal, or anal sex?  
  - No
  - Sometimes
  - Yes
  *If not, skip to the next section.*
- Have you had multiple partners in the past year?  
  - No
  - Sometimes
  - Yes
- Have you had both male and female partners?  
  - 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
- Do you smoke cigarettes or use e-cigarettes?  
  - No
  - Sometimes
  - Yes
- Do you chew tobacco or use other tobacco products?  
  - No
  - Sometimes
  - Yes
- Do you drink alcohol?  
  - No
  - Sometimes
  - Yes
- Have you used drugs, including marijuana, street drugs, inhalants, or steroids?  
  - 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 ride a bike, a skateboard, a motorcycle, or an ATV?  
  - Yes
  - Sometimes
  - No
- Do you ever use your phone or tablet while driving, even at stop signs?  
  - No
  - Sometimes
  - Yes
- Do you have someone you can call for a ride if you feel unsafe driving yourself or riding with someone else?  
  - Yes
  - Sometimes
  - No
### 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.
Well Young Adult | 18 Through 21 Year Visits

Accompanied By:                           Preferred Language:                 Date/Time:  
Name:  
Weight:                      Height:                          BMI:                            BP:  
ID Number:  
Vitals (if indicated):     Temp:                  HR:                   Resp Rate:          SpO2:  
Birth Date:                             Age:               Sex:           M            F  

HISTORY

Concerns and Questions: □ None
Interval History: □ None
Medical History: □ Young adult 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: ________________________
Menstrual problems: □ No    □ Yes: ________________________

Dental Home: □ No □ Yes: ______________ □ Regular visits
Brushing twice daily: □ Yes    □ No:__________________________
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:
Employmen: □ None □ Currently working: ________________________

Tobacco, alcohol, and drug use: □ None

Sexual Orientation/Gender Identity:

Sexual Activity: □ Denies

Mood: □ No concerns

The recommendations in this form do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original form 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 form and in no event shall the AAP be liable for any such changes.

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Well Young Adult  |  18 Through 21 Year Visits

**DEVELOPMENT**

- Forms caring, supportive relationships with family members, other adults, and peers
- Engages in a positive way with the life of the community
- Engages in behaviors that optimize wellness and contribute to a healthy lifestyle
  - Engages in healthy nutrition and physical activity behaviors
  - Chooses safety
- Demonstrates physical, cognitive, emotional, social, and moral competencies
- Exhibits compassion and empathy
- Exhibits resilience when confronted with life stressors
- Uses independent decision-making skills
- Displays a sense of self-confidence, hopefulness, and well-being

**SOCIAL AND FAMILY HISTORY**

Areas reviewed and updated as needed (See Initial History Questionnaire):  □ Social History  □ Family History

Changes since last visit: ____________________________  □ No interval change

Smoking household: □ No □ Yes: ____________________________

Firearms in home: □ No □ Yes: ____________________________

Young adult lives with: ____________________________

Relationships with parents/siblings: ____________________________

**REVIEW OF SYSTEMS**

- A 10-point review of systems was performed and results were negative except for any positive results listed below. Bold = Focus area for this Bright Futures Visit

  **Constitutional:**
  - Respiratory: ____________________________
  - Skin: ____________________________

  **Eyes:**
  - Gastrointestinal: ____________________________
  - Neurological: ____________________________

  **Head, Ears, Nose, and Throat:**
  - Genitourinary: ____________________________
  - Other: ____________________________

  **Cardiovascular:**
  - Musculoskeletal: ____________________________
  - Other: ____________________________

**PHYSICAL EXAMINATION**

- System examined  Bold = Focus area for this Bright Futures Visit

  Normal examination findings in text. Cross out abnormalities. Describe other findings in the area provided.

  □ General: Well-appearing young adult. Normal BMI and BP __________

  □ Eyes: Pupils equal, round, and reactive to light. Extraocular eye movements intact. Normal funduscopic examination findings. __________

  □ Ears, nose, mouth, and throat: Tympanic membranes with visible light reflex bilaterally. Healthy-appearing teeth without visible caries.

  □ Neck: Supple, with full range of motion and no significant adenopathy. __________

  □ Heart: Regular rate and rhythm. No murmur. __________

  □ Respiratory: Breath sounds clear bilaterally. Comfortable work of breathing. __________

  □ Abdomen: Soft, with no palpable masses. __________

  □ Genitourinary: Normal female external genitalia. __________

  □ Normal male external genitalia. No hydrocele, hernia, varicocele, or masses. No gynecomastia. __________

  □ 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. ________
    - Neurological: Normal gait. Normal strength and tone. ________
    - Skin: Warm and well perfused. No acanthosis nigricans. No atypical nevi. No signs of self-injury or abuse. No hirsutism. ________

Concerns: ____________________________
Well Young Adult | 18 Through 21 Year Visits

ASSESSMENT

- Well young adult
- Normal BMI
- Normal BP

**PLAN**

- **Immunizations:**
  - Vaccine Administration Record reviewed
  - Administered today: __________________________
  - Up-to-date for age

- **Universal Screening:**
  - Depression screening (annually): Screening tool used: __________________________ Result: ☐ Neg ☐ Pos: __________________________
  - Tobacco, alcohol, and drug use (annually): Screening tool used: __________________________ Result: ☐ Neg ☐ Pos: __________________________
  - Cervical dysplasia (women age 21): Result: ☐ Neg ☐ Pos: __________________________
  - HIV (once between 15 and 18): ☐ Completed age: __________________________ Result: ☐ Neg ☐ Pos: __________________________

- **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: __________________________

**ANTICIPATORY GUIDANCE**

- **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
  - Transition to adult care

- **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
  - Driving and substance use
  - Firearm safety

**PRINT NAME.**

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<thead>
<tr>
<th>Provider 1</th>
<th>Provider 2</th>
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**SIGNATURE**

Consistent with Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th Edition
HOW YOU ARE DOING
- Enjoy spending time with your family.
- Find activities you are really interested in, such as sports, theater, or volunteering.
- Try to be responsible for your schoolwork or work obligations.
- Always talk through problems and never use violence.
- If you get angry with someone, try to walk away.
- If you feel unsafe in your home or have been hurt by someone, let us know. Hotlines and community agencies can also provide confidential help.
- Talk with us if you are worried about your living or food situation. Community agencies and programs such as SNAP can help.
- Don’t smoke, vape, or use drugs. Avoid people who do when you can. Talk with us if you are worried about alcohol or drug use in your family.

YOUR FEELINGS
- Most people have ups and downs. If you are feeling sad, depressed, nervous, irritable, hopeless, or angry, let us know or reach out to another health care professional.
- Figure out healthy ways to deal with stress.
- Try your best to solve problems and make decisions on your own.
- Sexuality is an important part of your life. If you have any questions or concerns, we are here for you.

YOUR DAILY LIFE
- Visit the dentist at least twice a year.
- Brush your teeth at least twice a day and floss once a day.
- Be a healthy eater.
  ◦ 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 breakfast.
- Drink plenty of water.
- Make sure to get enough calcium every day.
  ◦ Have 3 or more servings of low-fat (1%) or fat-free milk and other low-fat dairy products, such as yogurt and cheese.
- Women: Make sure to eat foods rich in folate, such as fortified grains and dark-green leafy vegetables.
- Aim for at least 1 hour of physical activity every day.
- Wear safety equipment when you play sports.
- Get enough sleep.
- Talk with us about managing your health care and insurance as an adult.

HEALTHY BEHAVIOR CHOICES
- Avoid using drugs, alcohol, tobacco, steroids, and diet pills. Support friends who choose not to use.
- If you use drugs or alcohol, let us know or talk with another trusted adult about it. We can help you with quitting or cutting down on your use.
- Make healthy decisions about your sexual behavior.
- If you are sexually active, always practice safe sex. Always use birth control along with a condom to prevent pregnancy and sexually transmitted infections.
- All sexual activity should be something you want. No one should ever force or try to convince you.
- Protect your hearing at work, home, and concerts. Keep your earbud volume down.

18 THROUGH 21 YEAR VISITS—PATIENT

STAYING SAFE

- Always be a safe and cautious driver.
  - Insist that everyone use a lap and shoulder seat belt.
  - Limit the number of friends in the car and avoid driving at night.
  - Avoid distractions. Never text or talk on the phone while you drive.
- Do not ride in a vehicle with someone who has been using drugs or alcohol.
  - If you feel unsafe driving or riding with someone, call someone you trust to drive you.
- Wear helmets and protective gear while playing sports. Wear a helmet when riding a bike, a motorcycle, or an ATV or when skiing or skateboarding.
- Always use sunscreen and a hat when you’re outside.
- Fighting and carrying weapons can be dangerous. Talk with your parents, teachers, or doctor about how to avoid these situations.

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For more information, go to https://brightfutures.aap.org.