



Bright Futures Previsit Questionnaire Early Adolescent Visits

For us to provide you with the best possible health care, we would like to get to know you better and know how things are going for you. Our discussions with you are private. We hope you will feel free to talk openly with us about yourself and your health. Information is not shared with other people without your permission unless we are concerned that someone is in danger. Thank you for your time.

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today?

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

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

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

Your Growing and Changing Body	<input type="checkbox"/> Teeth <input type="checkbox"/> Appearance or body image <input type="checkbox"/> How you feel about yourself <input type="checkbox"/> Healthy eating <input type="checkbox"/> Good ways to be active <input type="checkbox"/> How your body is changing <input type="checkbox"/> Your weight
School and Friends	<input type="checkbox"/> Your relationship with your family <input type="checkbox"/> Your friends <input type="checkbox"/> How you are doing in school <input type="checkbox"/> Girlfriend or boyfriend <input type="checkbox"/> Organizing your time to get things done
How You Are Feeling	<input type="checkbox"/> Dealing with stress <input type="checkbox"/> Keeping under control <input type="checkbox"/> Sexuality <input type="checkbox"/> Feeling sad <input type="checkbox"/> Feeling anxious <input type="checkbox"/> Feeling irritable
Healthy Behavior Choices	<input type="checkbox"/> Smoking cigarettes <input type="checkbox"/> Drinking alcohol <input type="checkbox"/> Using drugs <input type="checkbox"/> Pregnancy <input type="checkbox"/> Sexually transmitted infections (STIs) <input type="checkbox"/> Decisions about sex and drugs
Violence and Injuries	<input type="checkbox"/> Car safety <input type="checkbox"/> Using a helmet or protective gear <input type="checkbox"/> Keeping yourself safe in a risky situation <input type="checkbox"/> Gun safety <input type="checkbox"/> Bullying or trouble with other kids <input type="checkbox"/> Not riding in a car with a drinking driver

Questions

Dyslipidemia	Do you smoke cigarettes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Alcohol or Drug Use	Have you ever had an alcoholic drink?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have you ever used marijuana or any other drug to get high?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
STIs	Have you ever had sex (including intercourse or oral sex)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Anemia	Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unsure
	Have you ever been diagnosed with iron deficiency anemia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

For Females Only

Anemia	Do you have excessive menstrual bleeding or other blood loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your period last more than 5 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

Growing and Developing

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

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



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Bright Futures Previsit Questionnaire Older Child/Early Adolescent Visits—For Parents

For us to provide your child with the best possible health care, we would like to know how things are going.
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?

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

Does your child have any special health care needs? No Yes, describe:

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

How many hours per day does your child watch TV, play video games, and use the computer (not for schoolwork)? _____

Questions About Your Child

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



For Females Only

Anemia	Does your child have excessive menstrual bleeding or other blood loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child's period last more than 5 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

Your Growing and Developing Child

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

- My child engages in behavior that supports a healthy lifestyle, such as eating healthy foods, being active, and keeping herself safe.
- My child has at least one responsible adult in his life who cares about him and to whom he can go to if he needs help.
- My child has at least one friend or a group of friends with whom she is comfortable.
- My child helps others individually or by working with a group in school, a faith-based organization, or the community.
- My child is able to bounce back from life's disappointments.
- My child has a sense of hopefulness and self-confidence.
- My child has become more independent and made more of his own decisions as he has become older.
- My child is particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting. Describe:



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