



Bright Futures Adolescent Supplemental Questionnaire 15 to 17 Year 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.

Your Name _____ Today's Date _____

Your Age _____ Your Sex (circle one): M F Your Grade (in school) _____

Your Growing and Changing Body: Physical Growth and Development

1.	Do you live in your parents' home?	Yes		No
2.	Do you go to school?	Yes		No
3.	Are you having any problems in school or at work? Circle all that apply: grades worse than last year fighting homework suspension in the last year missing school or work other _____	No		Yes
4.	Do you receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, or other healer)?	No		Yes
5.	Do you brush your teeth twice a day?	Yes		No
6.	Do you floss your teeth once a day?	Yes		No
7.	Have you been to the dentist in the last year?	Yes		No
8.	Do you eat 5 or more helpings of fruits and vegetables each day?	Yes		No
9.	Do you drink milk and eat yogurt, cheese, or other calcium-rich foods (such as dark-green leafy vegetables, or calcium-fortified orange juice or cereal) at least 3 times each day?	Yes	Sometimes	No
10.	Do you eat more than 1 fast food meal per week?	No	Sometimes	Yes
11.	Do you participate in any physical activities, such as walking, skateboarding, dancing, swimming, or playing basketball, for a total of 1 hour on a daily basis?	Yes		No
12.	Do you drink more than 1 soda or juice drink each day?	No		Yes
13.	Do you watch TV, play video games, or spend time on the computer for more than 2 hours per day (not including computer time for homework)?	No		Yes
14.	Do you have any concerns or questions about the size or shape of your body or your physical appearance?	No		Yes
15.	In the past year have you tried to lose weight or control your weight by vomiting, taking diet pills or laxatives, or starving yourself?	No		Yes
16.	Do you eat meals together as a family?	Yes		No

continued on page 2



Your Growing and Changing Body: Physical Growth and Development continued from page 1

17.	Are you, or do you ever wonder if you are, gay, lesbian, bisexual, or transgender?	No	Sometimes	Yes
18.	For girls: Have you gotten your period?	Yes		No
19.	If yes, are you having any problems with or do you have questions about your period?	No	Sometimes	Yes

Violence and Injuries: Violence and Injury Prevention

20.	Do you always wear a seat belt when you ride in or drive a car, truck, or van?	Yes	Sometimes	No
21.	Do you ever carry a gun?	No		Yes
22.	Do you or does anyone you live with have a gun, rifle, or other firearm?	No		Yes
23.	Do you wear a helmet when you play team sports, in-line skate, skateboard, bicycle, ski, snowboard, or ride a motorcycle, ATV, minibike, or snowmobile?	Yes	Sometimes	No
24.	Have you started to learn how to drive?	Yes		No
25.	Do you use a cell phone or headphones while driving?	No	Sometimes	Yes
26.	Have you ever had someone at home, school, or anywhere else who has made you feel afraid, threatened you, or hurt you?	No		Yes

How You Are Feeling: Emotional Well-being

27.	Even with usual ups and downs, do you feel you enjoy life?	Yes		No
28.	Do you get along with your family?	Yes	Sometimes	No
29.	Do you follow your family's rules?	Yes		No
30.	Do you worry a lot or feel overly stressed out?	No	Sometimes	Yes
31.	Are all of your relationships with girlfriends/boyfriends, friends, and family free of violence and abuse?	Yes		No
32.	When you are angry, do you do violent things?	No	Sometimes	Yes
33.	Do you find yourself continuing to remember or think about an unpleasant experience that happened in the past?	No	Sometimes	Yes
34.	During the past few weeks, have you often felt sad or down, had difficulty sleeping, or frequently felt irritable or as though you have nothing to look forward to?	No		Yes
35.	Have you ever seriously thought about killing yourself, made a plan, or actually tried to kill yourself?	No		Yes



Healthy Behavior Choices: Risk Reduction

36.	Have you ever			
	drank alcohol	No	Sometimes	Yes
	taken things to get high, stay awake, calm down, or go to sleep	No	Sometimes	Yes
	used marijuana	No	Sometimes	Yes
	used drugs (cocaine, crack, heroine, ecstasy, meth inhalants, or pills)	No	Sometimes	Yes
	If you answered "Yes" or "Sometimes," complete questions 37–42.			
37.	Have you ever ridden in a car driven by someone (including yourself) who was high or had been using alcohol or drugs?	No	Sometimes	Yes
38.	Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?	No	Sometimes	Yes
39.	Do you ever use alcohol or drugs while you are by yourself (alone)?	No		Yes
40.	Do you ever forget things you did while using alcohol or drugs?	No	Sometimes	Yes
41.	Do your family or friends ever tell you that you should cut down on your drinking or drug use?	No		Yes
42.	Have you ever gotten into trouble while you were using alcohol or drugs?	No		Yes
43.	Have you pierced your body (not including ears) or gotten a tattoo?	No		Yes
44.	Have you ever been forced or pressured to do something sexual that you haven't wanted to do?	No		Yes
45.	Have you ever had sex (including intercourse or oral sex)? If you answered "Yes," complete questions 46–49.	No		Yes
46.	Are you using a method to prevent pregnancy? (Which? _____)	Yes		No
47.	Have you ever been pregnant or gotten someone pregnant?	No		Yes
48.	Have your partners been both male and female?	No		Yes
49.	Do you think you or your partner could have a sexually transmitted infection?	No		Yes

CRAFFT used with permission from Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Arch Pediatr Adolesc Med.* 2002;156:607–614



American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

The recommendations in this publication 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 document included as part of *Bright Futures Tool and Resource Kit*. Copyright © 2010 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for any such changes.



Bright Futures Medical Screening Questionnaire

15 to 21 Year 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.

Please answer the following questions by circling Y, N, or Unsure.

Do you tend to squint?	Y	N	Unsure
Do you have trouble recognizing faces at a distance?	Y	N	Unsure
Do you hold books close to your eyes to read?	Y	N	Unsure
Do you complain that the blackboard has become difficult to see?	Y	N	Unsure
Have you ever failed a school vision screening test?	Y	N	Unsure
Do you have a problem hearing over the telephone?	Y	N	Unsure
Do you have trouble following the conversation when 2 or more people are talking at the same time?	Y	N	Unsure
Do you have trouble hearing with a noisy background?	Y	N	Unsure
Do you find yourself asking people to repeat themselves?	Y	N	Unsure
Do you misunderstand what others are saying and respond inappropriately?	Y	N	Unsure
Are you infected with HIV?	Y	N	Unsure
Have you ever been incarcerated (in jail)?	Y	N	Unsure
Were you born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?	Y	N	Unsure
Have you traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	Y	N	Unsure
Has a family member or contact had tuberculosis or a positive tuberculin skin test?	Y	N	Unsure
Do you have parents or grandparents who have had a stroke or heart problem before age 55?	Y	N	Unsure
Do you have a parent with an elevated blood cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?	Y	N	Unsure
Do you smoke cigarettes?	Y	N	Unsure
Have you ever had an alcoholic drink?	Y	N	Unsure
Have you ever used marijuana or any other drug to get high?	Y	N	Unsure
Do you now or have you ever used injectable drugs?	Y	N	Unsure



Have you ever been diagnosed with iron deficiency anemia?	Y	N	Unsure
Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	N	Y	Unsure

FOR FEMALES ONLY

Does your period last more than 5 days?	Y	N	Unsure
Do you have excessive menstrual bleeding or other blood loss?	Y	N	Unsure
Have you ever had sex (including intercourse or oral sex)?	Y	N	Unsure
Are you having unprotected sex with multiple partners?	Y	N	Unsure
Do you trade sex for money or drugs or have sex partners who do?	Y	N	Unsure
Have any of your past or current sex partners been infected with HIV, bisexual, or injection drug users?	Y	N	Unsure
Have you ever been treated for a sexually transmitted infection?	Y	N	Unsure
Was your first time having sexual intercourse more than 3 years ago?	Y	N	Unsure
Have you been sexually active and had a late or missed period within the last 2 months?	Y	N	Unsure
Have you been sexually active without using birth control?	Y	N	Unsure

FOR MALES ONLY

Have you ever had sex (including intercourse or oral sex)?	Y	N	Unsure
Are you having unprotected sex with multiple partners?	Y	N	Unsure
Do you trade sex for money or drugs or have sex partners who do?	Y	N	Unsure
Have any of your past or current sex partners been infected with HIV, bisexual, or injection drug users?	Y	N	Unsure
Have you ever been treated for a sexually transmitted infection?	Y	N	Unsure
Have you ever had sex with other men?	Y	N	Unsure



American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

The recommendations in this publication 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 document included as part of *Bright Futures Tool and Resource Kit*. Copyright © 2010 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for any such changes.