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?	○ 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
	Have you ever been diagnosed as having iron deficiency anemia?	○ No	○ Yes	○ Unsure
	Do you or your family ever struggle to put food on the table?	○ No	○ Yes	○ Unsure
	For females: Do you have excessive menstrual bleeding or other blood loss?	○ No	○ Yes	○ Unsure
	For females: Does your period last more than 5 days?	○ No	○ Yes	○ 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)?	○ No	○ Yes	○ Unsure
	Do you have a parent with an elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication?	○ No	○ Yes	○ Unsure
	Do you smoke cigarettes or use e-cigarettes?	○ No	○ Yes	○ Unsure
Sexually transmitted infections/ HIV	Have you ever had sex, including intercourse or oral sex? **IF NO, SKIP TO THE NEXT SECTION (HIV).**	○ No	○ Yes	○ Unsure
	Are you having unprotected sex?	○ No	○ Yes	○ Unsure
	Are you having sex with multiple partners or anonymous partners?	○ No	○ Yes	○ Unsure
	Are you or any of your past or current sexual partners bisexual?	○ No	○ Yes	○ Unsure
	Have you ever been treated for a sexually transmitted infection?	○ No	○ Yes	○ Unsure
	Have any of your past or current sex partners been infected with HIV or used injection drugs?	○ No	○ Yes	○ Unsure
	Do you trade sex for money or drugs or have sex partners who do?	○ No	○ Yes	○ Unsure
	For males: Have you ever had sex with other males?	○ No	○ Yes	○ Unsure
HIV	Do you now use or have you ever used injection drugs?	○ No	○ Yes	○ Unsure
Tuberculosis	Are you infected with HIV?	○ No	○ Yes	○ 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)?	○ No	○ Yes	○ Unsure
	Have you had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	○ No	○ Yes	○ Unsure
Vision	Have you ever failed a school vision screening test?	○ No	○ Yes	○ Unsure
	Do you have concerns about your vision?	○ No	○ Yes	○ Unsure
	Do you have trouble with near or far vision?	○ No	○ Yes	○ Unsure
	Do you tend to squint?	○ No	○ Yes	○ 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?	○ Yes	○ Sometimes	○ No
Do you have ways that help you deal with feeling angry?	○ Yes	○ Sometimes	○ No
Have you been in a fight in the past 12 months?	○ No	○ Sometimes	○ Yes
Do you know anyone in a gang?	○ No	○ Sometimes	○ Yes
Do you belong to a gang?	○ No	○ Sometimes	○ 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.	○ 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? *If not, skip to the next section.*	○ No	○ Sometimes	○ Yes
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

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.

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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:	SpO_2:	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:

Employment: ☐ None ☐ Currently working: _____

Tobacco, alcohol, and drug use: ☐ None

Sexual Orientation/Gender Identity:

Sexual Activity: ☐ Denies

Mood: ☐ No concerns

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Name: _____

DEVELOPMENT

☑ = Normal development ☐ See Previsit Questionnaire.

- ☐ 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

Concerns: _____

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.**

_____

Name: _____

ASSESSMENT

☐ Well young adult ☐ Normal BMI ☐ Normal BP

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
- 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

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: _____

PRINT NAME.	SIGNATURE
Provider 1	
Provider 2	

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BRIGHT FUTURES HANDOUT ▶ **PATIENT**

18 THROUGH 21 YEAR VISITS

Here are some suggestions from Bright Futures experts that may be of value to you.

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.

Helpful Resource: National Domestic Violence Hotline: 800-799-7233

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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