PATIENT NAME: _____ DATE: _____

Please print.

11 THROUGH 14 YEAR VISITS FOR PATIENTS (SENSITIVE QUESTIONS INCLUDED)

RISK ASSESSMENT

Anemia	Does your diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	O Yes	O No	O Unsure
	Do you eat a vegetarian diet (do not eat red meat, chicken, fish, or seafood)?	O No	O Yes	O Unsure
	If you are a vegetarian (do not eat red meat, chicken, fish, or seafood), do you take an iron supplement?	O Yes	O No	O Unsure
	For girls: Do you have excessive menstrual bleeding or other blood loss?	O No	O Yes	O Unsure
	For girls: Does your period last more than 5 days?	O No	O Yes	O Unsure
Dyslipidemia	Do you smoke cigarettes or use e-cigarettes?	O No	O Yes	O Unsure
Sexually transmitted infections/ HIV	Have you ever had sex, including intercourse or oral sex? **IF NO, SKIP TO THE NEXT SECTION (HIV).**	O No	O Yes	O Unsure
	Are you having unprotected sex?	O No	O Yes	O Unsure
	Are you having sex with multiple partners or anonymous partners?	O No	O Yes	O Unsure
	Are you or any of your past or current sexual partners bisexual?	O No	O Yes	O Unsure
	Have you ever been treated for a sexually transmitted infection?	O No	O Yes	O Unsure
	Have any of your past or current sex partners been infected with HIV or used injection drugs?	O No	O Yes	O Unsure
	Do you trade sex for money or drugs or have sex partners who do?	O No	O Yes	O Unsure
	For boys: Have you ever had sex with other males?	O No	O Yes	O Unsure
HIV	Do you now use or have you ever used injection drugs?	O No	O Yes	O Unsure
Tuberculosis	Are you infected with HIV?	O No	O Yes	O 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)?	O No	O Yes	O Unsure
	Have you had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	O No	O Yes	O Unsure
Vision	Do you have concerns about how well you see?	O No	O Yes	O Unsure

ANTICIPATORY GUIDANCE

How are things going for you and your family?

HOW YOU ARE DOING

Interpersonal Violence (Fighting and Bullying)			
Have you been part of a gang or a group that has gotten or could get into trouble?	O No	O Sometimes	O Yes
Have you been in a fight in the past 6 months?	O No	O Sometimes	O Yes
Do you know anyone in a gang?	O No	O Sometimes	O Yes
Do you have ways that help you deal with feeling angry?	O Yes	O Sometimes	O No
Do you feel safe at home?	O Yes	O Sometimes	O No
Have you ever been bullied in person, on the Internet, or through social media?	O No	O Sometimes	O Yes
Have you been in a relationship with a person who threatened you physically or hurt you?	O No	O Sometimes	O Yes
Have you ever been touched in a way that made you feel uncomfortable?	O No	O Sometimes	O Yes
Has anyone touched your private parts without your agreement or against your wishes?	O No	O Sometimes	O Yes
Have you ever been forced or pressured to do something sexually that you didn't want to do?	O No	O Sometimes	O Yes
Connectedness With Family and Peers			
Do you spend time talking with your parents every day?	O Yes	O Sometimes	O No
Do your parents praise you when you do something good or learn something new?	O Yes	O Sometimes	O No

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11 THROUGH 14 YEAR VISITS FOR PATIENTS (SENSITIVE QUESTIONS INCLUDED)

HOW YOU ARE DOING (*CONTINUED*)

Connectedness With Family and Peers (*continued*)			
Do you get along with your family?	O Yes	O Sometimes	O No
Does your family do things together?	O Yes	O Sometimes	O No
Do you have an adult you feel connected to?	O Yes	O Sometimes	O No
Do you have rules at home and know what happens when you break the rules?	O Yes	O Sometimes	O No
Connectedness With Community			
Do you have activities or things you like to do after school or on the weekends?	O Yes	O Sometimes	O No
Do you help others at home, in school, or in your community?	O Yes	O Sometimes	O No
School Performance			
Are you doing well at school?	O Yes	O Sometimes	O No
Do you have things you enjoy doing at school?	O Yes	O Sometimes	O No
Are you having any problems in school? Are there things you need help figuring out?	O No	O Sometimes	O Yes
Do you get extra help or support in any subjects at school?	O No	O Sometimes	O Yes
Coping With Stress and Decision-making			
Do you worry a lot or feel overly stressed out?	O No	O Sometimes	O Yes
Do you have things you do to feel better when you are stressed?	O Yes	O Sometimes	O No

YOUR GROWING AND CHANGING BODY

Healthy Teeth			
Do you brush your teeth twice a day?	O Yes	O Sometimes	O No
Do you see the dentist twice a year?	O Yes	O Sometimes	O No
If you play contact sports, do you wear a mouth guard?	O Yes	O Sometimes	O No
Body Image			
Do you have any concerns about your weight?	O No	O Sometimes	O Yes
Are you teased 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 healthy food options at home and in 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
Physical Activity and Sleep			
Are you physically active at least 1 hour a day? This includes running, playing sports, or active play with friends.	O Yes	O Sometimes	O 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?	O Yes	O Sometimes	O No
Do you have trouble sleeping?	O No	O Sometimes	O 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?	O No	O Sometimes	O Yes
Have you talked with your parents about dating and sex?	O Yes	O Sometimes	O No
Do you have questions or concerns about how your body is changing (puberty)?	O No	O Sometimes	O Yes

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11 THROUGH 14 YEAR VISITS FOR PATIENTS (SENSITIVE QUESTIONS INCLUDED)

EMOTIONAL WELL-BEING (*CONTINUED*)

For girls: Have you started your period?	O No	O Sometimes	O Yes
For girls: If yes, do you have any concerns about your period (such as not regular, heavy bleeding, or bad cramping)?	O No	O Sometimes	O Yes

HEALTHY BEHAVIOR CHOICES

Romantic Relationships and Sexual Activity			
Have you ever been in a romantic relationship?	O No	O Sometimes	O Yes
If yes, have you always felt safe and respected?	O Yes	O Sometimes	O No
Have you ever had sex, including oral, vaginal, or anal sex? *If no, skip to the next section.*	O No	O Sometimes	O Yes
Do you and your partner use condoms every time?	O Yes	O Sometimes	O No
Do you and your partner always use another form of birth control along with a condom?	O Yes	O Sometimes	O No
Are you aware of emergency contraception?	O Yes	O Sometimes	O No
Tobacco, E-cigarettes, Alcohol, and Prescription or Street Drugs			
Have you ever smoked cigarettes or used e-cigarettes?	O No	O Sometimes	O Yes
Have you ever drunk alcohol?	O No	O Sometimes	O Yes
Have you ever been offered any drugs?	O No	O Sometimes	O Yes
Have you ever used drugs (including marijuana or street drugs)?	O No	O Sometimes	O Yes
Have you ever taken prescription drugs that were not given to you for a medical condition?	O No	O Sometimes	O Yes
Acoustic Trauma			
Do you use earplugs or sound-canceling headphones to protect your hearing around loud noises or at concerts?	O Yes	O Sometimes	O No
Do you often listen to loud music?	O No	O Sometimes	O Yes

STAYING SAFE

Seat Belt and Helmet Use			
Do you always wear a lap and shoulder seat belt?	O Yes	O Sometimes	O No
Do you always wear a helmet to protect your head when you are biking, skateboarding, or skating?	O Yes	O Sometimes	O No
Do you always wear a life jacket when you do water sports?	O Yes	O Sometimes	O No
Sun Protection			
Do you use sunscreen?	O Yes	O Sometimes	O No
Do you visit tanning parlors?	O No	O Sometimes	O Yes
Substance Use and Riding in a Vehicle			
Have you ever ridden in a car with someone who has been drinking or using drugs?	O No	O Sometimes	O Yes
Do you have someone you can call for a ride if you feel unsafe riding with someone?	O Yes	O Sometimes	O No
Gun Safety			
Have you ever carried a gun or knife (even for self-protection)?	O No	O Sometimes	O Yes
If there is a gun in your home, do you know how to get hold of it?	O No	O Sometimes	O 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.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

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.

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

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