Bright Futures Adolescent Supplemental Questionnaire 18 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.

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 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 protect your ears when you are around loud noise?	**Yes**		**No**
9.	Do you eat 5 or more helpings of fruits and vegetables each day?	**Yes**		**No**
10.	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**
11.	Do you eat more than 1 fast food meal per week?	**No**	**Sometimes**	**Yes**
12.	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**
13.	Do you drink more than 1 soda or juice drink each day?	**No**		**Yes**
14.	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**
15.	Do you have any concerns or questions about the size or shape of your body or your physical appearance?	**No**		**Yes**
16.	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**

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Your Growing and Changing Body: Physical Growth and Development

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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**
20.	Are you involved in your community with an issue that concerns or interests you?	**Yes**		**No**
21.	Do you eat meals together as a family?	**Yes**		**No**

Violence and Injuries: Violence and Injury Prevention

22.	Do you always wear a seat belt when you ride in or drive a car, truck, or van?	**Yes**	**Sometimes**	**No**
23.	Do you ever carry a gun?	**No**		**Yes**
24.	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**
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**
27.	Have you ever felt upset by an experience using the Internet?	**No**		**Yes**

How You Are Feeling: Emotional Well-being

28.	Even with usual ups and downs, do you feel you enjoy life?	**Yes**		**No**
29.	Do you get along with your family?	**Yes**	**Sometimes**	**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 46–50.**	No		Yes
46.	Do you and your partner(s) *always* use condoms when you have sex?	Yes		No
47.	Are you using a method to prevent pregnancy? (Which?________________________________)	Yes		No
48.	Have you ever been pregnant or gotten someone pregnant?	No		Yes
49.	Have your partners been both male and female?	No		Yes
50.	Do you think you or your partner could have a sexually transmitted infection?	No		Yes

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Bright Futures Medical Screening Questionnaire 15 to 21 Year Visits

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

Question			
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

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