

ACCOMPANIED BY/INFORMANT		PREFERRED LANGUAGE		DATE/TIME		Name	
DRUG ALLERGIES			CURRENT MEDICATIONS			ID NUMBER	
WEIGHT (%)	HEIGHT (%)	BMI (%)	BLOOD PRESSURE		BIRTH DATE	AGE M F	

Visit with: ☐ Teen alone ☐ Parent(s) alone ☐ Mother ☐ Father ☐ Teen with parents ☐ Other _____

History

☐ Previsit Questionnaire reviewed	☐ Teen has special health care needs
☐ Teen has a dental home	

Concerns and questions ☐ None ☐ Addressed (see other side)

Follow-up on previous concerns ☐ None ☐ Addressed (see other side)

Interval history ☐ None ☐ Addressed (see other side)

Menarche: Age _____ Regularity _____

Menstrual problems _____

☐ Medication Record reviewed and updated

Social/Family History

See Initial History Questionnaire. ☐ No interval change

Changes since last visit _____

Teen lives with _____

Relationship with parents/siblings _____

Risk Assessment

If not reviewed in Supplemental Questionnaire
(Use other side if risks identified.)

HOME

- Eats meals with family ☐ Yes ☐ No
- Has family member/adult to turn to for help ☐ Yes ☐ No
- Is permitted and is able to make independent decisions ☐ Yes ☐ No

EDUCATION

- Grade _____
- Performance ☐ NL _____
- Behavior/Attention ☐ NL _____
- Homework ☐ NL _____

EATING

- Eats regular meals including adequate fruits and vegetables ☐ Yes ☐ No
- Drinks non-sweetened liquids ☐ Yes ☐ No
- Calcium source ☐ Yes ☐ No
- Has concerns about body or appearance ☐ Yes ☐ No

ACTIVITIES

- Has friends ☐ Yes ☐ No
- At least 1 hour of physical activity/day ☐ Yes ☐ No
- Screen time (except for homework) less than 2 hours/day ☐ Yes ☐ No
- Has interests/participates in community activities/volunteers ☐ Yes ☐ No

DRUGS (Substance use/abuse)

- Uses tobacco/alcohol/drugs ☐ Yes ☐ No

SAFETY

- Home is free of violence ☐ Yes ☐ No
- Uses safety belts/safety equipment ☐ Yes ☐ No
- Impaired/Distracted driving ☐ Yes ☐ No
- Has relationships free of violence ☐ Yes ☐ No

SEX

- Has had oral sex ☐ Yes ☐ No
- Has had sexual intercourse (vaginal, anal) ☐ Yes ☐ No

SUICIDALITY/MENTAL HEALTH

- Has ways to cope with stress ☐ Yes ☐ No
- Displays self-confidence ☐ Yes ☐ No
- Has problems with sleep ☐ Yes ☐ No
- Gets depressed, anxious, or irritable/has mood swings ☐ Yes ☐ No
- Has thought about hurting self or considered suicide ☐ Yes ☐ No

Physical Examination

☒ = NL

Bright Futures Priority

☐ SKIN

☐ BACK/SPINE

☐ BREASTS

☐ GENITALIA

SEXUAL MATURITY RATING _____

Additional Systems

☐ GENERAL APPEARANCE	☐ TEETH
☐ HEAD	☐ LUNGS
☐ EYES	☐ HEART
☐ EARS	☐ GI/ABDOMEN
☐ NOSE	☐ EXTREMITIES
☐ MOUTH AND THROAT	☐ NEUROLOGIC
☐ NECK	☐ MUSCULO-SKELETAL

Abnormal findings and comments _____

Assessment

☐ Well teen

Anticipatory Guidance

☐ Discussed and/or handout given

☐ PHYSICAL GROWTH AND DEVELOPMENT	• Friends/relationships • Family time • Community involvement • Encourage reading/school • Rules/Expectations • Planning for after high school	☐ RISK REDUCTION
• Balanced diet • Physical activity • Limit TV • Protect hearing • Brush/Floss teeth • Regular dentist visits	• Tobacco, alcohol, drugs • Prescription drugs • Sex	☐ VIOLENCE AND INJURY PREVENTION
☐ SOCIAL AND ACADEMIC COMPETENCE	• Decision-making • Mood changes • Sexuality/Puberty	• Seat belts • Guns • Conflict resolution • Driving restriction • Sports/Recreation safety

Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results: ☐ Vision ☐ Cholesterol (18–21 years)

☐ Referral to _____

Follow-up/Next visit _____

☐ See other side

Print Name	Signature
PROVIDER 1	
PROVIDER 2	



Psychosocial Risks
Confidential (To be completed confidentially for teens with identified risk)

Home
Relationship with parents/guardians
Violence in home
Teen's concerns
Autonomy
Counseling/Recommendations

Education
Teen's concerns
Social interactions
Conflicts
Counseling/Recommendations

Eating
Usual diet
Attempts to lose weight by dieting, laxatives, or self-induced vomiting
Regular meals (includes breakfast, limits fast food)
Counseling/Recommendations

Activities
Clubs/Extracurricular
Music/Art
Sports
Religious/Community
TV/Electronics hours/day
Gangs
Counseling/Recommendations

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
HEEADSSS used with permission from Goldenring JM, Rosen DS. Getting into adolescent heads: an essential update.
Contemp Pediatr. 2004;21:64-90
This American Academy of Pediatrics Visit Documentation Form is consistent with Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition.
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.
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Drugs (Substance Use/Abuse)
Tobacco use
Alcohol
Drugs (street/prescription)
Steroids
CRAFFT (+2 indicates need for follow-up)
C - Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
R - Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
A - Do you ever use alcohol or drugs while you are by yourself, ALONE?
F - Do you ever FORGET things you did while using alcohol or drugs?
F - Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?
T - Have you gotten into TROUBLE while you were using alcohol or drugs?
Counseling/Recommendations

Safety
Impaired/Distracted driving
Sports/recreation safety
Guns
Peer violence
Dating violence
Counseling/Recommendations

Sex
Oral sex
Has had sexual intercourse (vaginal, anal)
Age of onset of sexual activity
Number of partners
Gender of partners
Sexual orientation
Condom use
Contraception
Previous pregnancy
Previous STI
Laboratory/Screening results
Pregnancy test
Pap smear
Chlamydia/Gonorrhea, source
Syphilis
HIV
STI screening laboratory results (specify)
Counseling/Recommendations

Suicidality/Mental Health
Depression
Anxiety
Suicide ideation
Suicide attempts
History of psychologic counseling
Other mental health diagnosis
Counseling/Recommendations

Confidentiality discussed With teen With parent(s)