W.A.S.H

Wilson Area School Health

W.A.S.H. Center
1210 Forest Hills Road NW
Wilson, NC 27893
252-360-0769

Dear Parent:

The Wilson County School Based Health Center advocates for the health of children and addresses a broad range of needs. Our purpose is to provide affordable, and accessible, physical, and preventive health services to adolescents.

The Wilson County School Based Health Center here at Forest Hills Middle School and Beddingfield High School is located on the campus and is open Monday through Friday from 8am to 4pm. The staff includes a full time Registered Nurse, an Advanced Practice Provider (APP), and an Office Coordinator.

Students with health insurance or Medicaid coverage will be asked to provide information to allow for billing of medical services. Students without insurance coverage will be billed on a sliding fee scale according to their household income and number of supported members in the household. Please contact our office to discuss income sources. The Wilson County School Based Health Center **can bill most commercial insurances and Medicaid.** No sick student that has a signed consent form will be turned away for failure to pay or lack of insurance.

The goal for the Wilson County School Based Health Center is to help students succeed in school by promoting healthy lifestyles, and providing comprehensive health care to meet the needs of all students.

If you have any questions or concerns, please contact Wilson County Health Department at 252-237-3141 or the W.A.S.H. Center at 252-360-0769. We appreciate your interest and support of the Wilson County School Based Health Center.

Thank you,

W.A.S.H. Center Staff

Student Name: _____

Student Date of Birth: _____ Grade: _____

WILSON COUNTY SCHOOL BASED HEALTH CENTER NOTICE OF PRIVACY PRACTICES

WE ARE REQUIRED BY LAW TO PROTECT MEDICAL INFORMATION ABOUT YOU.

Each time you visit a hospital, physician or healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you receive
- Means by which you or a third-party payer can verify that services billed were actually provided a tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the nation
- A source of data for facility planning and marketing
- A tool we can assess and continually work to improve the care we render and outcomes we achieve

Understanding what is in your record and how your health information is used to help you to ensure its accuracy, better understand who, what, when, where, and why others may access your information so you can make more informed decisions when authorizing disclosures to others.

Your Health Information Rights

Although your health record is the physical property of the healthcare provider or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information
- Obtain an accounting of disclosures of your health information
- Request communication of your health information by alternative means or locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

This organization (Wilson County School Based Health Center) is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we were unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

Examples of Disclosures for Treatment, Payment and Health Operations

- We will use your health information with treatment
- We will use your health information for payment
- We will use your health information for regular health operation

Business Associates: There are some services provided in our organization through contracts with business associates. When these services are contracted, we may disclose your health information to them so that they can provide the service we've asked them to do and bill you at your third party payer for services rendered. All standards of confidentiality are rendered under Wilson County Health Department policy.

Notification: We may disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product/product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health: As required by law, we may disclose your health information or public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or in the public.

If you have any questions concerning these Privacy Practices you may contact the privacy Officer at (252) 237-3141.

I have read and understand the Notice of Privacy Practices of the Wilson County School Based Health Center.

Signature_____ **Date**_____

Wash

Wilson Area School Health

MINOR PATIENT REGISTRATION

By completing this form, I consent in advance to my child having access to any and all-available services of the Wilson Area School Health program as long as my child remains enrolled in Forest Hills Middle or Beddingfield High Schools. Services include: diagnosis and treatment of common illnesses and injuries; laboratory testing; preventative health screenings; health education; nutrition counseling and referrals as needed. Services rendered may include telemedicine services.

Students must have parental permission to be seen by Wilson Area School Health.

Student's Name (First, Middle, Last): _____ DOB: _____

SSN: _____ Age: _____ Gender: F M School: _____

Mailing Address: _____ City: _____ Zip: _____

Primary Phone: _____ Parent E-Mail: _____

Mother/ Legal Guardian: _____ DOB: _____ SSN: _____ Phone: _____

Father/Legal Guardian: _____ DOB: _____ SSN: _____ Phone: _____

Who does the child live most of the time: _____

Race: White Black American Indian Native Alaskan Asian Native Hawaiian Other Pacific Islander

Ethnicity: (Circle One) Hispanic Non-Hispanic

In case of emergency, please tell us a local friend or relative (not living at the same address) whom we can contact:

Name: _____ Relationship: _____ Ph: _____

Person responsible for the Bill: _____

Is the Patient covered by Insurance/ Medicaid? YES or NO

Please fill in all of the following:

Primary Insurance: Name of Insurance Company: _____ CoPay Amount: _____

Insurance ID Number: _____ Group Number: _____

Name of Subscriber: _____ DOB: _____ SSN: _____

Patient's Relationship to Subscriber: SELF SPOUSE CHILD OTHER: _____

Secondary Insurance: Name of Insurance Company: _____ CoPay Amount: _____

Insurance. ID Number: _____ Group Number: _____

Name of Subscriber: _____ DOB: _____ SSN: _____

Patient's Relationship to Subscriber: SELF SPOUSE CHILD OTHER: _____

PRIMARY CARE DOCTOR/CLINIC: _____

PHARMACY: _____ City: _____ Phone #: _____

Please fill out all information that applies.

Revised March 2018

Wash

Wilson Area School Health

MINOR PATIENT REGISTRATION

Child's Name: _____ DOB: _____

HIPAA/FERPA: All students have health issues that must be handled in a confidential manner. Wilson Area School Health staff will share confidential information **only** in the following situations:

- with written parental consent
- when it is educationally relevant for a student's academic progress.
- when it is necessary to address a student's potential health care needs.
- to ensure the safety of the student, other students and school personnel
- other situations specified by law

For example, the Wilson Area School Health staff may discuss the student's mediation and other health care needs with the appropriate staff member who will administer the student's medication and provide care to the student while the student is in school.

Additional detailed information about the Privacy Policies that govern Wilson Area School Health and Telemedicine Program are available on our website at www.wilson-co-com/departments/health-department .

I, the undersigned,

- give permission and consent for my child to have treatment through and by Wilson Area School Health. I understand the nature of this treatment, the way it is provided, and the details and limitations of the telemedicine component of the services offered.
- give permission for Wilson Area School Health to receive information from the school about my child's health history.
- acknowledge that I have been offered a copy of the Notice of Privacy Practices (available on our website at www.wilson-co.com/departments/health-department or at the Wilson Area School Health center located at Forest Hills Middle and Beddingfield High Schools).
- agree to release all records related to this treatment to the Primary Care Provider.
- Agree that all I will be responsible for all costs associated with said treatment and tha I will provide any insurance information as requested. All costs and fees not covered by insurance will be my responsibility.
- As Parent/Legal Guardian of the above student, I:
    - authorize the release of any information necessary to process insurance claims for payment of benefits to Wilson Area School Health/Wilson County Health department.
    - authorize payment of benefits to Wilson Area School Health/Wilson County Health Department for services rendered.
    - have provided details of all insurance policies that cover my child.

The information above and on the preceding page is true and complete to the best of my knowledge.

Beddingfield Student (If ≥18 y/o only): _____

Parent/Legal Guardian name **PRINTED**: _____

Parent/Legal Guardian **SIGNATURE:** _____

Date: _____

Revised March 2018

Wash

Wilson Area School Health

MINOR PATIENT REGISTRATION

EMERGENCY TREATMENT

An emergency exists if, in the judgement of the Wilson Area School Health staff, treatment is immediately required to prevent deterioration or worsening of a patient' condition. In emergency situations requiring acute care, Wilson Area School Health personnel will contact the Emergency Medical System for transport of the student to the appropriate medical facility for evaluation and treatment. In case of emergency, whom may we contact?

	Name	Phone Number	Relationship to Student
1.			
2.			

Revised March 2018

Student Name: _____

Student Date of Birth: _____ Grade: _____

ALLERGIES AND MEDICATIONS:

Today's Date _____

Has your child had a physical in the last 12 months? Yes _____ No _____

If yes, where? _____ Please provide the date of last exam: _____

Is your child allergic to any medicines? Yes _____ No _____
If yes, please list: _____

Is your child allergic to any foods? Yes _____ No _____
If yes, please list: _____

Is your child currently taking any medicine? Yes _____ No _____
If yes, please provide the following information on the medicines taken:

Name of Medicine	Dosage	How is it taken?	Reason taken?	How long taken?
Ex: Zyrtec	10 mg	1 per day	Seasonal Allergies	3 years

Has your child ever been hospitalized overnight? Yes _____ No _____
If yes, give age at the time of hospitalization and describe the problem:

Age	Problem

HOUSEHOLD INFORMATION

Please provide the following information regarding your household:

Name of Person in Household	Date of Birth	Age	Relationship to Student	Health Status
Ex: John Doe	1/10/1972	45	Father	Diabetes Type 1

Wilson County
Health Department

1801 Glendale Drive SW • Wilson, NC 27893-4401 • Phone 252.237.3141

AUTHORIZATION AND CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

Table to be completed by Provider:

PATIENT NAME: _____ LOCATION OF PATIENT: _____	DATE OF BIRTH: _____	MEDICAL RECORD #: _____
PROVIDER NAME: _____ LOCATION OF PROVIDER: _____		

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Wilson Area School Health providing healthcare services to me via telemedicine.

Wilson Area School Health's provider has explained to me how the video conferencing technology will be used. I understand that this consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or myself can discontinue the telemedicine consult/visit if it is felt that the video conferencing connections are not adequate for the situation.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Wilson Area School Health at

(252) 399-7913. As long as this consent is in force (has not been revoked) Wilson Area School Health may provide health services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient (or person authorized to sign for patient):

Signature: _____ Date: _____

If authorized signer, relationship to patient: _____

Witness: _____ Date: _____

REVOCATION:

I refuse to participate in the telemedicine health services as described above:

Signature: _____ *Date:* _____

Wilson Area School Health

Child's Name _____

Grade _____

Date of Birth _____

W.A.S.H. Center
1210 Forest Hills Road NW
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INFLUENZA

IT'S TIME TO GET READY FOR FLU SEASON

Dear Parent:

The WASH Clinic will be providing flu shots to the Forest Hills Middle School family in the coming days. Please sign below stating if you consent or decline your child receiving a flu shot during school hours. Though a completed WASH Consent form is NOT required to receive the flu shot, it is recommended to confirm any prior issues with receiving the flu vaccine or known allergies.

I consent to _____ receiving the flu vaccine while at school.
For insurance filing purposes, please provide the following.
Insurance Provider _____ Policy Number_____

I decline to _____ receiving the flu vaccine while at school.

_____ _____
Signature of Parent or Guardian Date

Reminder: Fall sports are coming up. If your child has not received a sports physical and needs one, please call or have them come by the WASH Center to make a sports physical appointment. Sports Physical and Concussion forms must be signed by a parent and guardian prior to appointment time.

The Wilson County School Based Health Center here at Forest Hills Middle School is located on the campus and is open Monday through Friday from 8am to 4pm. The staff includes a full time Registered Nurse, an Advance Practice Provider (APP), and an Office Coordinator. ***The WASH Center is a separate entity from the school nurse.*** The WASH Center can perform services just as a regular doctor's office can. In order for the WASH Center to assess your child for any health issues, a completed WASH Consent packet is required to be on file in the center. WASH consent packets as well as the Sports Physical and Concussion forms can be picked up from the WASH Center or can be found on our website at http://washclinic.weebly.com/.

If you have any questions or concerns, please contact Wilson County Health Department at 252-237-3141 or the W.A.S.H. Center at 252-360-0769. We appreciate your interest and support of the Wilson County School Based Health Center.

Thank you, W.A.S.H. Center Staff

NC Child Health Program Initial History Questionnaire *(created 7/1/2012)*

Patient Name:	Date of Birth:	Sex: (Circle) Male Female
Person Who Filled Out Form: Date Filled Out:	Relationship to Patient:	

PREGNANCY AND BIRTH HISTORY

Is the child adopted? No Yes
Birth Weight: _____ pounds _____ ounces
Was baby born on time? No Yes _____ weeks
Was the birth Vaginal C-Section If C-Section, Why?_____

Were there any problems during the pregnancy or at birth?
No Yes If yes, explain: _____

During pregnancy did mom:
Use tobacco? No Yes Drink alcohol? No Yes
Use drugs or other medications? No Yes What: _____
Use prenatal vitamins? No Yes When:_____
Did baby have problems or need to stay in a NICU?
No Yes If yes, explain: _____
The initial feeding for the baby was: Formula Breast milk
How long did the baby breastfeed? _____
Did the baby go home with mom? No Yes
If no, explain: _____

HOUSEHOLD

List names, relationships to child, and ages of all people living with the child:

_____
_____
_____

Are there siblings not listed? If so, list names, ages and where they live:

_____
_____

What is your child's living situation?

Joint custody Single custody Foster care

If one or both parents are not living in the home, how often does the child see the parent not in the home?

_____

Tobacco use in family? No Yes Who?: _____

CHILD'S HEALTH HISTORY

Has the **child** ever had:

Hospitalizations	No	Yes
Serious Injuries/Broken Bones	No	Yes
Surgeries	No	Yes
Allergies To Medications/Other: _____	No	Yes
Chicken Pox (Year) _____	No	Yes
Frequent Ear Infections	No	Yes
Vision/Hearing Problems	No	Yes
Nasal Allergies	No	Yes
Asthma /Lung Problems	No	Yes
Tuberculosis(TB)/Risks for TB	No	Yes
Any Heart Problems/Murmur	No	Yes
Anemia/Sickle Cell	No	Yes
Bleeding Problems/Transfusion	No	Yes
Immune Problems/HIV	No	Yes
Cancer	No	Yes
Stomach Aches/Constipation	No	Yes
Bladder Infections/Kidney Disease	No	Yes
Birth Defects	No	Yes
Metabolic/Genetic Conditions	No	Yes
Sleep/Snoring/Bed Wetting Issues	No	Yes
Chronic Skin Problems/Eczema	No	Yes
Frequent Headaches	No	Yes
Seizures/Neurological Problems	No	Yes
Obesity	No	Yes
Diabetes	No	Yes
Thyroid/Endocrine Problems	No	Yes
High Blood Pressure	No	Yes
Alcohol/Drug Use/Tobacco	No	Yes
ADHD/Anxiety/Mood/Depression	No	Yes
Developmental Delay/Disability	No	Yes
Dental Decay/Cavities	No	Yes
History of Family Violence/Abuse	No	Yes
Sexual Infections/Pregnancy	No	Yes
Elevated Lead Level	No	Yes
Other: _____	No	Yes

BIOLOGICAL FAMILY HEALTH HISTORY

Has anyone **in the family of the child** (parents, grandparents, sisters/brothers) had:

			Who?
Childhood Hearing Loss	No	Yes	_____
Nasal Allergies	No	Yes	_____
Asthma	No	Yes	_____
Tuberculosis (TB)/Risks for Tuberculosis	No	Yes	_____
Lung Problems	No	Yes	_____
Heart Disease	No	Yes	_____
High Blood Pressure/Stroke	No	Yes	_____
High Cholesterol/Takes Cholesterol Medication	No	Yes	_____
Anemia/Sickle Cell	No	Yes	_____
Bleeding Problems	No	Yes	_____
Dental Decay (cavities)	No	Yes	_____
Cancer	No	Yes	_____
Liver Disease/Hepatitis	No	Yes	_____
Kidney Disease	No	Yes	_____
Diabetes (high blood sugar)	No	Yes	_____
Obesity	No	Yes	_____
Seizures/Epilepsy	No	Yes	_____
Alcohol Abuse	No	Yes	_____
Drug Abuse	No	Yes	_____
Mental Illness/Depression	No	Yes	_____
Development Delay/Disability	No	Yes	_____
Immune Problems/HIV/AIDS	No	Yes	_____
Other Family History: _____	No	Yes	_____

Additional Comments:

Bright Futures

Bright Futures Previsit Questionnaire
Older Child/Early Adolescent Visits—For Parents

For us to provide your child with the best possible health care, we would like to know how things are going.
Thank you.

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today?

What changes or challenges have there been at home since last year?

Does your child have any special health care needs? ☐ No ☐ Yes, describe:

Does your child live with anyone who uses tobacco or spend time in any place where people smoke? ☐ No ☐ Yes, describe:

How many hours per day does your child watch TV, play video games, and use the computer (not for schoolwork)? _____

Questions About Your Child

Vision	Does your child complain that the blackboard has become difficult to see?	☐ Yes	☐ No	☐ Unsure
	Has your child ever failed a school vision screening test?	☐ Yes	☐ No	☐ Unsure
	Does your child hold books close to read?	☐ Yes	☐ No	☐ Unsure
	Does your child have trouble recognizing faces at a distance?	☐ Yes	☐ No	☐ Unsure
	Does your child tend to squint?	☐ Yes	☐ No	☐ Unsure
Hearing	Does your child have a problem hearing over the telephone?	☐ Yes	☐ No	☐ Unsure
	Does your child have trouble following the conversation when 2 or more people are talking at the same time?	☐ Yes	☐ No	☐ Unsure
	Does your child have trouble hearing with a noisy background?	☐ Yes	☐ No	☐ Unsure
	Does your child ask people to repeat themselves?	☐ Yes	☐ No	☐ Unsure
	Does your child misunderstand what others are saying and respond inappropriately?	☐ Yes	☐ No	☐ Unsure
Tuberculosis	Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?	☐ Yes	☐ No	☐ Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	☐ Yes	☐ No	☐ Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	☐ Yes	☐ No	☐ Unsure
	Is your child infected with HIV?	☐ Yes	☐ No	☐ Unsure
Dyslipidemia	Does your child have parents or grandparents who have had a stroke or heart problem before age 55?	☐ Yes	☐ No	☐ Unsure
	Does your child have a parent with an elevated blood cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?	☐ Yes	☐ No	☐ Unsure
Anemia	Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	☐ No	☐ Yes	☐ Unsure
	Has your child ever been diagnosed with iron deficiency anemia?	☐ Yes	☐ No	☐ Unsure

For Females Only

Anemia	Does your child have excessive menstrual bleeding or other blood loss?	☐ Yes	☐ No	☐ Unsure
	Does your child's period last more than 5 days?	☐ Yes	☐ No	☐ Unsure

Your Growing and Developing Child

Check off all of the items that you feel are true for your child.

- ☐ My child engages in behavior that supports a healthy lifestyle, such as eating healthy foods, being active, and keeping herself safe
- ☐ My child has at least one responsible adult in his life who cares about him and to whom he can go to if he needs help.
- ☐ My child has at least one friend or a group of friends with whom she is comfortable.
- ☐ My child helps others individually or by working with a group in school, a faith-based organization, or the community
- ☐ My child is able to bounce back from life's disappointments.
- ☐ My child has a sense of hopefulness and self-confidence.
- ☐ My child has become more independent and made more of his own decisions as he has become older
- ☐ My child is particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting. Describe:

Bright Futures Previsit Questionnaire
15 to 17 Year Visits

Bright Futures.

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.

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today?

What changes or challenges have there been at home since last year?

Do you have any special health care needs? ☐ No ☐ Yes ☐ Unsure, describe:

Do you live with anyone who uses tobacco or spend time in any place where people smoke? ☐ No ☐ Yes, describe:

How many hours per day do you watch TV, play video games, and use the computer (not for schoolwork)?

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

Your Growing and Changing Body	☐ How your body is changing ☐ Teeth ☐ Appearance or body image ☐ How you feel about yourself ☐ Healthy eating ☐ Good ways to keep active ☐ Protecting your ears from loud noise
School and Friends	☐ Your relationship with your family ☐ Your friends ☐ Girlfriend or boyfriend ☐ How you are doing in school ☐ Organizing your time to get things done ☐ Plans after high school
How You Are Feeling	☐ Dealing with stress ☐ Keeping under control ☐ Sexuality ☐ Feeling sad ☐ Feeling anxious ☐ Feeling irritable ☐ Keeping a postitive attitude
Healthy Behavior Choices	☐ Pregnancy ☐ Sexually transmitted infections (STIs) ☐ Smoking cigarettes ☐ Drinking alcohol ☐ Using drugs ☐ How to avoid risky situations ☐ Decisions about sex, alcohol, and drugs ☐ How to support friends who don't use alcohol and drugs ☐ How to follow through with decisions you have made about sex, alcohol, and drugs
Violence and Injuries	☐ Car safety ☐ Using a helmet ☐ Driving rules for new teen drivers ☐ Gun safety ☐ Dating violence or abuse ☐ Bullying or trouble with other kids ☐ Keeping yourself and your friends safe in risky situations

Questions

Vision	Do you complain that the blackboard has become difficult to see?	☐ Yes	☐ No	☐ Unsure
	Have you ever failed a school vision screening test?	☐ Yes	☐ No	☐ Unsure
	Do you hold books close to your eyes to read?	☐ Yes	☐ No	☐ Unsure
	Do you have trouble recognizing faces at a distance?	☐ Yes	☐ No	☐ Unsure
	Do you tend to squint?	☐ Yes	☐ No	☐ Unsure
Hearing	Do you have a problem hearing over the telephone?	☐ Yes	☐ No	☐ Unsure
	Do you have trouble following the conversation when 2 or more people are talking at the same time?	☐ Yes	☐ No	☐ Unsure
	Do you have trouble hearing with a noisy background?	☐ Yes	☐ No	☐ Unsure
	Do you find yourself asking people to repeat themselves?	☐ Yes	☐ No	☐ Unsure
	Do you misunderstand what others are saying and respond inappropriately?	☐ Yes	☐ No	☐ Unsure
Tuberculosis	Were you born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?	☐ Yes	☐ No	☐ Unsure
	Have you traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	☐ Yes	☐ No	☐ Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	☐ Yes	☐ No	☐ Unsure
	Have you ever been incarcerated (in jail)?	☐ Yes	☐ No	☐ Unsure
	Are you infected with HIV?	☐ Yes	☐ No	☐ Unsure
Dyslipidemia	Do you have parents or grandparents who have had a stroke or heart problem before age 55?	☐ Yes	☐ No	☐ Unsure
	Do you have a parent with an elevated blood cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?	☐ Yes	☐ No	☐ Unsure
	Do you smoke cigarettes?	☐ Yes	☐ No	☐ Unsure
Anemia	Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	☐ No	☐ Yes	☐ Unsure
	Have you ever been diagnosed with iron deficiency anemia?	☐ Yes	☐ No	☐ Unsure

Alcohol or Drug Use	Have you ever had an alcoholic drink?	☐ Yes	☐ No	☐ Unsure
	Have you ever used marijuana or any other drug to get high?	☐ Yes	☐ No	☐ Unsure
STIs	Do you now use or have you ever used injectable drugs?	☐ Yes	☐ No	☐ Unsure
	For Females Only			
Anemia	Do you have excessive menstrual bleeding or other blood loss?	☐ Yes	☐ No	☐ Unsure
	Does your period last more than 5 days?	☐ Yes	☐ No	☐ Unsure
STIs	Have you ever had sex (including intercourse or oral sex)? **(If no, skip to Growing and Developing)**	☐ Yes	☐ No	☐ Unsure
	Have any of your past or current sex partners been infected with HIV, bisexual, or injection drug users?	☐ Yes	☐ No	☐ Unsure
	Have you ever been treated for a sexually transmitted infection?	☐ Yes	☐ No	☐ Unsure
	Are you having unprotected sex with multiple partners?	☐ Yes	☐ No	☐ Unsure
	Do you trade sex for money or drugs or have sex partners who do?	☐ Yes	☐ No	☐ Unsure
Cervical Dysplasia	Was your **first** time having sexual intercourse more than 3 years ago?	☐ Yes	☐ No	☐ Unsure
Pregnancy	Have you been sexually active without using birth control?	☐ Yes	☐ No	☐ Unsure
	Have you been sexually active and had a late or missed period within the last 2 months?	☐ Yes	☐ No	☐ Unsure
	For Males Only			
STIs	Have you ever had sex (including intercourse or oral sex)? **(If no, skip to Growing and Developing)**	☐ Yes	☐ No	☐ Unsure
	Have you ever been treated for a sexually transmitted infection?	☐ Yes	☐ No	☐ Unsure
	Are you having unprotected sex with multiple partners?	☐ Yes	☐ No	☐ Unsure
	Have you ever had sex with other men?	☐ Yes	☐ No	☐ Unsure
	Do you trade sex for money or drugs or have sex partners who do?	☐ Yes	☐ No	☐ Unsure
	Have any of your past or current sex partners been infected with HIV, bisexual, or injection drug users?	☐ Yes	☐ No	☐ Unsure

Growing and Developing

Check off all the items that you feel are true for you.

- ☐ I engage in behavior that supports a healthy lifestyle, such as eating healthy foods, being active, and keeping myself safe.
- ☐ I feel I have at least one responsible adult in my life who cares about me and who I can go to if I need help.
- ☐ I feel like I have at least one friend or a group of friends with whom I am comfortable.
- ☐ I help others on my own or by working with a group in school, a faith-based organization, or the community.
- ☐ I am able to bounce back from life's disappointments.
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- ☐ I have become more independent and made more of my own decisions as I have become older.
- ☐ I feel that I am particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting. Describe:

Bright Futures Previsit Questionnaire
18 to 21 Year Visits

Bright Futures.

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.

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today?

What changes or challenges have there been at home since your last visit?

Do you have any special health care needs? ❑ No ❑ Yes, describe

Do you live with anyone who uses tobacco or spend time in any place where people smoke? ❑ No ❑ Yes, describe:

How many hours per day do you watch TV, play video games, and use the computer (not for schoolwork)?

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

Your Growing and Changing Body	❑ How your body is changing ❑ Teeth ❑ Appearance or body image ❑ How you feel about yourself ❑ Healthy eating ❑ Good ways to be active ❑ Protecting your ears from loud noise
School and Friends	❑ How you are doing in school ❑ Organizing your time to get things done ❑ Your job ❑ Your future plans ❑ Your friends ❑ Girlfriend or boyfriend ❑ Your relationship with your family
How You Are Feeling	❑ Dealing with stress ❑ Keeping under control ❑ Making decisions on your own ❑ Sexuality ❑ Depression ❑ Feeling anxious ❑ Feeling irritable ❑ Feeling sad
Healthy Behavior Choices	❑ Pregnancy ❑ Sexually transmitted infections (STIs) ❑ Smoking cigarettes ❑ Drinking alcohol ❑ Using drugs ❑ How to avoid risky situations ❑ How to support friends who don't use alcohol and drugs ❑ How to follow through with decisions you have made about sex and drugs
Violence and Injuries	❑ Avoiding driving distractions ❑ Drinking and driving ❑ Gun safety ❑ Dating violence or abuse

Questions

Vision	Do you complain that the blackboard has become difficult to see?	❑ Yes	❑ No	❑ Unsure
	Have you ever failed a school vision screening test?	❑ Yes	❑ No	❑ Unsure
	Do you hold books close to your eyes to read?	❑ Yes	❑ No	❑ Unsure
	Do you have trouble recognizing faces at a distance?	❑ Yes	❑ No	❑ Unsure
	Do you tend to squint?	❑ Yes	❑ No	❑ Unsure
Hearing	Do you have a problem hearing over the telephone?	❑ Yes	❑ No	❑ Unsure
	Do you have trouble following the conversation when 2 or more people are talking at the same time?	❑ Yes	❑ No	❑ Unsure
	Do you have trouble hearing with a noisy background?	❑ Yes	❑ No	❑ Unsure
	Do you find yourself asking people to repeat themselves?	❑ Yes	❑ No	❑ Unsure
	Do you misunderstand what others are saying and respond inappropriately?	❑ Yes	❑ No	❑ Unsure
Tuberculosis	Were you born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?	❑ Yes	❑ No	❑ Unsure
	Have you traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	❑ Yes	❑ No	❑ Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	❑ Yes	❑ No	❑ Unsure
	Have you ever been incarcerated (in jail)?	❑ Yes	❑ No	❑ Unsure
	Are you infected with HIV?	❑ Yes	❑ No	❑ Unsure
Dyslipidemia	Do you have parents or grandparents who have had a stroke or heart problem before age 55?	❑ Yes	❑ No	❑ Unsure
	Do you have a parent with an elevated blood cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?	❑ Yes	❑ No	❑ Unsure
	Do you smoke cigarettes?	❑ Yes	❑ No	❑ Unsure
Anemia	Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	❑ No	❑ Yes	❑ Unsure
	Have you ever been diagnosed with iron deficiency anemia?	❑ Yes	❑ No	❑ Unsure

Alcohol or Drug Use	Have you ever had an alcoholic drink?	❑ Yes	❑ No	❑ Unsure
	Have you ever used marijuana or any other drug to get high?	❑ Yes	❑ No	❑ Unsure
STIs	Do you now use or have you ever used injectable drugs?	❑ Yes	❑ No	❑ Unsure

For Females Only

Anemia	Do you have excessive menstrual bleeding or other blood loss?	❑ Yes	❑ No	❑ Unsure
	Does your period last more than 5 days?	❑ Yes	❑ No	❑ Unsure
STIs	Have you ever had sex (including intercourse or oral sex)? (If no, skip to Growing and Developing)	❑ Yes	❑ No	❑ Unsure
	Have any of your past or current sex partners been infected with HIV, bisexual, or injection drug users?	❑ Yes	❑ No	❑ Unsure
	Have you ever been treated for a sexually transmitted infection?	❑ Yes	❑ No	❑ Unsure
	Are you having unprotected sex with multiple partners?	❑ Yes	❑ No	❑ Unsure
	Do you trade sex for money or drugs or have sex partners who do?	❑ Yes	❑ No	❑ Unsure
Cervical Dysplasia	Was your first time having sexual intercourse more than 3 years ago?	❑ Yes	❑ No	❑ Unsure
Pregnancy	Have you been sexually active without using birth control?	❑ Yes	❑ No	❑ Unsure
	Have you been sexually active and had a late or missed period within the last 2 months?	❑ Yes	❑ No	❑ Unsure

For Males Only

STIs	Have you ever had sex (including intercourse or oral sex)? (If no, skip to Growing and Developing)	❑ Yes	❑ No	❑ Unsure
	Have you ever been treated for a sexually transmitted infection?	❑ Yes	❑ No	❑ Unsure
	Are you having unprotected sex with multiple partners?	❑ Yes	❑ No	❑ Unsure
	Have you ever had sex with other men?	❑ Yes	❑ No	❑ Unsure
	Do you trade sex for money or drugs or have sex partners who do?	❑ Yes	❑ No	❑ Unsure
	Have any of your past or current sex partners been infected with HIV, bisexual, or injection drug users?	❑ Yes	❑ No	❑ Unsure

Growing and Developing

Check off all the items that you feel are true for you.

- ❑ I engage in behavior that supports a healthy lifestyle, such as eating healthy foods, being active, and keeping myself safe.
- ❑ I feel I have at least one responsible adult in my life who cares about me and who I can go to if I need help.
- ❑ I feel like I have at least one friend or a group of friends with whom I am comfortable.
- ❑ I help others on my own or by working with a group in school, a faith-based organization, or the community.
- ❑ I am able to bounce back from life's disappointments.
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