# Adolescents

- Abdominal Examination
- Alcohol Misuse
- Anemia
- Bacteriuria
- Blood Pressure Screening
- Breastfeeding
- Cervical Cancer Screening and Prevention
- Contraception, STIs, and Reproductive Health
- Depression
- Diabetes
- Diabetes Postpartum
- Diet, Fitness, Nutrition
- Domestic and Intimate Partner Violence
- Drug Use
- Genetic Screening
- Hepatitis B Screening
- Hepatitis C Screening
- Immunizations
- Injury Prevention
- Mental Health and Psychosocial Issues/ Suicide/Behavioral Assessment
- Metabolic Syndrome
- Neural Tube Defects
- Obesity
- Oral Hygiene
- Pelvic Examination
- Piercing and Tattooing
- Preconception/Interconception Care
- Sexual Health
- Skin Cancer
- Tobacco Use
- Visual Acuity/Glaucoma

| Final WWTF Recommendation and Strength of Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| "Strong" = Based on evidence-based or evidence-informed guidelines<br>"Qualified" = Based on expert opinion alone | Foundation for WWTF recommendations. Primarily USPSTF, IOM, and CDC guidelines. | Additional guidelines from medical societies used for developing consensus recommendations. | WWTF expert consensus: Describes resolution of conflicting guidelines or outlines expert opinion that does not have a strong evidence foundation. |

## TOPIC: ABDOMINAL EXAMINATION

*Adolescents (13–21 years)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **An abdominal examination is an appropriate component of the well-adolescent visit. (Qualified)** | | General: Standard physical examination taught in medical school and advanced practice programs includes abdominal examination as part of a routine periodic examination. The elements can include four-quadrant/nine-region abdominal inspection, auscultation, percussion, and palpation. Inspection can reveal distention, operative and traumatic scars, striae, pubic hair distribution, jaundice, and distended veins. Auscultation can reveal bowel sounds and fetal heart sounds. Percussion can reveal ascites. Palpation can assess superficial or deep tenderness, guarding, rebound tenderness, and rigidity.<br>ACOG: Abdominal examination is recommended as part of well-woman physical examination regardless of age.[1,2,3]<br>AAP Bright Futures: Annual well-child assessment and physical examination is recommended. At this visit, an age-appropriate physical examination is essential. The older child (11–21 years) will be undressed and suitably draped.[4] | |

## TOPIC: ALCOHOL MISUSE

*Adolescents (13–18 years)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Annual screening of adolescents for alcohol use by questionnaire, history, or both (not by laboratory testing) is recommended. Positive screening should prompt provision or referral of patient to counseling about alcohol use. (Strong)** | USPSTF: There is inconclusive evidence that counseling is effective in adolescents.[5] | AAP Bright Futures: Recommends annual evaluation and counseling for alcohol use in adolescents.[6]<br>AAP: Strongly advises against the use of alcohol, tobacco, and other illicit drugs by youth.[7]<br>ACOG: Recommends annual screening for alcohol use in teens.[8] Recommends screening by questionnaire, history, or both (not by laboratory testing) at least yearly.[9]<br>PCHHC: All women of childbearing age should be screened for alcohol use, and brief interventions should be provided in primary care settings, which should include advice regarding the potential for adverse health outcomes. Women who show signs of alcohol dependence should be educated about the risks of alcohol consumption; for women who are interested in modifying their alcohol use patterns, efforts should be made to identify programs that would assist them in achieving cessation and long-term abstinence (B I-a).[10] Assess at least annually for alcohol use patterns and risky drinking behaviors and provide appropriate counseling; all women should be advised of the risks to the embryo/fetus of alcohol exposure in pregnancy and that no safe level of consumption has been established (A-III).[10]<br>AAFP: The evidence is inconclusive that counseling is effective in adolescents. Recommends screening and behavioral counseling interventions in primary care settings to reduce alcohol misuse.[11]<br>CDC: Binge drinking increases the risk of unintended pregnancy, delayed pregnancy recognition, STIs, and adverse pregnancy outcomes, including fetal alcohol spectrum disorder.[12]<br>NIAAA: Recommends alcohol screening and brief intervention for youth.[13] | |

## TOPIC: ANEMIA

*Adolescents and Adults (all ages)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Routine screening for anemia is not recommended. (Qualified)** | USPSTF: Evidence is insufficient to recommend for or against routine iron supplementation for nonanemic pregnant women (Grade I).[14] | There is no recommendation for routine screening for anemia in asymptomatic girls or women. | |

## TOPIC: BACTERIURIA

*Adolescents (13–18 years)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Screening for bacteriuria in asymptomatic nonpregnant women is not recommended. (Strong)** | USPSTF: Recommends against screening for asymptomatic bacteriuria in nonpregnant women.[15] | AAFP: Recommends against screening for asymptomatic bacteriuria in men and nonpregnant women.[16] | There is evidence of harm resulting from treatment of asymptomatic bacteriuria in nonpregnant women. There is no evidence of benefit to screening older, asymptomatic, nonpregnant women. Recommend following USPSTF guidelines. |

## TOPIC: BLOOD PRESSURE SCREENING

*Adolescents & Adults (all ages)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Routine blood pressure screening is recommended. (Strong)** | USPSTF: Screen for high blood pressure in adults aged 18 years or older. Current evidence is insufficient to assess the balance of benefits and harms of screening for hypertension in asymptomatic children and adolescents to prevent subsequent cardiovascular disease in childhood or adulthood.[17, 18] | AAFP: There is insufficient evidence to recommend for or against screening children and adolescents for high blood pressure to reduce risk of cardiovascular disease.[19]<br>AAP Bright Futures: Recommends routine blood pressure measurement for adolescents.[6] | |

## TOPIC: BREASTFEEDING

*All Women of Reproductive Capacity*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Promotion of breastfeeding and counseling is recommended for all pregnant and postpartum women to ensure successful initiation and duration of breastfeeding. Provide interventions such as comprehensive lactation support and counseling and information on the costs of renting breastfeeding equipment to promote and support breastfeeding. (Strong)** | IOM: Recommends women's preventive services include comprehensive lactation support and counseling and costs of renting breastfeeding equipment. A trained provider should provide counseling services to all pregnant women and to those in the postpartum period to ensure the successful initiation and duration of breastfeeding.[20]<br>USPSTF: Recommends interventions during pregnancy and after birth to promote and support breastfeeding (Grade B).[21] | AAP: Recommends exclusive breastfeeding for about 6 months, followed by continued breastfeeding as complementary foods are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant.[22]<br>ACNM: Provide timely and ongoing counseling and support for breastfeeding. Maternity/newborn facilities must follow lactation-friendly policies.[23]<br>AAFP: Recommends interventions during pregnancy and after birth to promote and support breastfeeding.[24] | |

## TOPIC: CERVICAL CANCER SCREENING AND PREVENTION

*Adolescents (13–20 years) Screening*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Screening for cervical cancer is not recommended for women younger than 21 years. (Strong)** | USPSTF: Screening is not recommended for cervical cancer in women younger than 21 years. The recommendation does not apply to women who have received a diagnosis of a high-grade precancerous cervical lesion or cervical cancer, women with in utero exposure to diethylstilbestrol, or women who are immunocompromised (such as those who are HIV positive).[25]<br>ACS/ASCCP/ACSP: Cervical cancer screening should begin at age 21 years. Women younger than 21 years should not be screened regardless of the age of sexual initiation or other risk factors.[26] | ACOG: Screening is not recommended for adolescents.[27]<br>AAFP: Screening is not recommended for adolescents.[28] | Healthy women younger than 21 years should not be screened. |

*Adolescents (13–20 years) HPV Vaccination*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **HPV vaccine is recommended for adolescents, preferably before the initiation of sexual activity and according to the ACIP schedule. (Strong)** | ACIP: Girls aged 11 years or 12 years should receive bivalent or quadrivalent HPV vaccine. The vaccine can be given as early as 9 years of age and should be given to women aged 13–26 years who have not been previously vaccinated.[29] | AAP, AAFP, ACP, ACOG, ACNM: ACIP adult and childhood vaccination schedules are endorsed.[30, 31]<br>AWHONN: Human papillomavirus vaccine is recommended.[32] | Adolescents should receive HPV vaccine prior to the initiation of sexual activity. |
| **There are conflicting vaccination guidelines for HIV-infected girls and women younger than 21 years. Adherence to ACIP/CDC vaccination guidelines is acceptable. (Qualified)** | CDC: For those who are HIV positive, a Pap test should be obtained twice during the first year after diagnosis of HIV infection and, if the results are normal, annually thereafter.[33] | ACOG: Annual cytology screening starting at age 21 years is reasonable for this group.[27] | |

## TOPIC: CONTRACEPTION, STIs, AND REPRODUCTIVE HEALTH
(*See also* Alcohol Misuse, Preconception/ Interconception Care, Sexual Health)

*Adolescents (13–18 years) Methods*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Adolescents of reproductive capacity should be counseled regarding contraceptive methods (including postponing sexual activity); ensured access to basic contraceptive services, either within the office setting or by referral to appropriate services; and offered appropriate follow up to ensure adherence and monitor for adverse effects and complications. (Strong)** | IOM, CDC: Recommends that women with reproductive capacity have access to the full range of FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling.[20, 34]<br>CDC: Prevent unwanted or unintended pregnancy by assessing the woman's need for contraceptive methods and those that are available for her. | ACOG: Recommends preventing unwanted and unintended pregnancy by postponing sexual involvement or using contraceptive options, including emergency contraception.[2, 35] Recommends first reproductive care visit at ages 13–15 years, prior to sexual activity (usually does not include a pelvic examination).[36]<br>AAP: Pediatricians should counsel about and ensure access to a broad range of contraceptive services for their adolescent patients.[37]<br>AAP Bright Futures: Integrate sexuality education into the longitudinal relationship developed through care experiences with the preadolescent child, the adolescent, and the family.[38] | Adolescent visit provides an opportunity to establish a relationship. Content of visit can include screening, education, and guidance on sexual development, menses, HPV vaccine, preventing pregnancy, STIs, and other sexual health issues.[39] |

*Adolescents (13–18 years) Screening/Testing*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Annual chlamydia and gonorrhea testing is recommended for those who are sexually active. (Strong)** | CDC: Routine screening for *Neisseria gonorrhoeae* in all sexually active women at risk of infection is recommended annually. Women aged 25 years or younger are at highest risk of gonorrhea infection. Routine screening for *Chlamydia trachomatis* of all sexually active females aged 25 years or younger is recommended annually.[40]<br>USPSTF: Recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk of infection (that is, if they are young or have other individual or population risk factors). Women and men younger than 25 years—including sexually active adolescents—are at highest risk of genital gonorrhea infection (Grade B).[41] Recommends screening for chlamydia infection for all sexually active, nonpregnant young women aged 24 years and younger and for older nonpregnant women who are at increased risk (Grade A).[42] Recommends high-intensity behavioral counseling to prevent STIs for all sexually active adolescents and for adults at increased risk of STIs (Grade B).[43] | AAP: Routine laboratory screening for nonviral STIs as recommended in published screening guidelines for sexually active adolescents.[44] These recommendations summarize published federal agency and medical professional organizations' clinical guidance for all sexually active adolescents.<br>ACOG: Recommends chlamydia and gonorrhea testing, if sexually active. Urine-based STI screening is an efficient method without a speculum examination.[2] | |

## TOPIC: DEPRESSION

*Adolescents (13–18 years)*
*(See also Mental Health and Psychosocial Issues/Suicide/Behavioral Assessment, Preconception/Interconception Care)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Annual screening of adolescents for depressive disorders, using a validated tool, is recommended. (Qualified)**<br>**Screening postpartum adolescents for depression, using a validated tool, is recommended. (Qualified)** | USPSTF: Recommends screening adolescents (12–18 years of age) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up (Grade B).[46] | AMA: Screen adolescents who may be at risk as a result of family problems, drug or alcohol use, or other indicators of risk.[47, 48]<br>AAP Bright Futures: Recommends universal screening for depression in adolescents aged 11–21 years. Ask questions about depression in routine history-taking throughout adolescence. Patients with depression risk factors should be identified and systematically monitored over time.[4]<br>AAFP: Screen for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.[49]<br>AWHONN: Health care facilities that serve pregnant women, new mothers, and newborns should have routine screening protocols and educational mechanisms for staff training and education related to postpartum mood and anxiety disorders.[50]<br>ACOG: Recommends asking annually about emotions and behaviors that indicate recurrent or severe depression and thoughts of killing or harming themselves.[8] Recommends screening in practices that have systems in place to ensure accurate diagnosis, treatment, and follow up.[3]<br>ACNM: Recommends universal screening, treatment, or referral for depression as part of routine primary health care. Recommends increasing the number of postpartum visits for all women.[51] | Patients should not be denied recommended screening because of any limitation of local resources. Rather, providers should have plans for referral, even if it means the patient will have to travel outside her community. Providers are encouraged to develop initial management skills that are within the scope of their specialty and practice to meet local patient needs. Patients should be counseled about limitations in local resources at the time of testing. |

## TOPIC: DIABETES

*Adolescents (13–18 years)*
*(See also Diabetes Postpartum; Diet, Fitness, Nutrition; Obesity)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Routine screening for diabetes in adolescents is not recommended except for those who are obese, defined as a BMI of 30 or higher. (Qualified)** | | | There is no recommendation for routine screening in asymptomatic adolescents. |

## TOPIC: DIABETES POSTPARTUM

*All Women of Reproductive Capacity*
*(See also Diabetes)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **For patients with a history of gestational diabetes, laboratory screening for diabetes is recommended at 6–12 weeks postpartum and follow-up screening at least every 3 years is recommended. (Strong)** | | ACOG: Recommends screening 6–12 weeks postpartum, then every 3 years.[52]<br>American Diabetes Association: Recommends screening 6–12 weeks postpartum, then every 3 years.[53] | |

## TOPIC: DIET, FITNESS, NUTRITION

*Adolescents and Adults (all ages)*
*(See also Obesity, Preconception/Interconception Care)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Routine weight assessment using BMI calculation is recommended. For women with risk factors for diet-related chronic disease, BMI less than 19 or greater than 25, assessment of diet, nutritional status, and physical activity, followed by intensive counseling and behavioral interventions, is recommended. (Qualified)** | USPSTF: Recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. All adult patients should be screened for obesity and offered intensive counseling and behavioral interventions.[54] | ACOG: Recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. All adult patients should be screened for obesity and offered intensive counseling and behavioral interventions. Also recommends evaluation and counseling on physical activity.[2]<br>American Dietetic Association: Recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. All adult patients should be screened for obesity and offered intensive counseling and behavioral interventions. Also recommends evaluation and counseling on physical activity.[55]<br>AAP Bright Futures: Recommends assessing BMI annually.[4] | All agree that diet, nutrition, and exercise are keys to good health and improved health and can prevent illness. However, the science on how this is best accomplished is debatable. |

## TOPIC: DOMESTIC AND INTIMATE PARTNER VIOLENCE

*Adolescents (13–18 years)*
*(See also Preconception/Interconception Care)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Screening is recommended at least annually for intimate partner violence, such as domestic violence or reproductive or sexual coercion. Provide or refer women who screen positive to intervention services. (Strong)** | USPSTF: Current evidence is insufficient to assess the balance of benefits and harms of primary care interventions to prevent child maltreatment (aged 0–18 years) (Grade I).[56] Recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services (Grade B).[57]<br>IOM: Screening and counseling involve elicitation of information from women and adolescents about current and past violence and abuse in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems.[20] | AAP: Consider screening adolescents if they say they have a new intimate partner, when signs or symptoms raise concerns, or during any prenatal visits.[6] Screen for intimate partner violence and sexual coercion at least annually and with each new partner. (If a patient has multiple visits, for example for pregnancy or STI testing, consider these as clinical indictors to assess more frequently.[6])<br>ACOG: Screen periodically in all women (eg, annual visit, new patient, postpartum visit) and in women at risk (signs of depression, substance abuse, mental health problems, requests for repeat pregnancy tests when the woman does not wish to be pregnant, new or recurrent STIs, requests for STI testing, expresses fear when negotiating condom use).[58] Signs or symptoms of abuse or neglect should prompt risk assessment. Evidence of neglect or abuse must be reported to law enforcement agencies as required by state or federal laws and regulations.[59] | |

## TOPIC: DRUG USE

*Adolescents (13–18 years)*
*(See also Preconception/Interconception Care)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **At least annual screening for substance abuse by history (not laboratory testing) is recommended. Provide or refer patients to counseling as needed. (Strong)** | USPSTF: Current evidence is insufficient to assess the balance of benefits and harms of screening adolescents, adults, and pregnant women for illicit drug use (Grade I).[60] | ACOG: Recommends annual screening by questionnaire or history (not laboratory testing) for illicit drugs, prescription and nonprescription medications, and performance-enhancing drugs.[8] Evaluate and counsel on substance use other than alcohol and tobacco.[8]<br>AAP: Evaluation and counseling and screening are part of an age-appropriate comprehensive history. Recommends annual screening for alcohol, tobacco, and substance abuse. Strongly advise against the use of alcohol, tobacco, and other illicit drugs by youth.[6]<br>PCHHC: A careful history should be obtained to identify use of illegal substances as part of the preconception risk assessment. Men and women should be counseled about the risks of using illicit drugs before and during pregnancy and offered information on programs that support abstinence and rehabilitation. Contraception services should be offered, and pregnancy should be delayed until individuals are drug-free.[61]<br>AAFP: Current evidence is insufficient to assess the balance of benefits and harms of screening adolescents, adults, and pregnant women for illicit drug use (Grade I).[62]<br>NAHIC: Recommends annual screening and counseling for substance abuse.[63]<br>AHRQ: Screen by history for substance use at every health maintenance examination or initial pregnancy visit (repeat as indicated), using a validated screening tool (improves accuracy of detecting substance abuse or dependence) (Grade D).[64]<br>NCQA: Healthcare Effectiveness Data and Information Set discusses engagement in treatment and referral for smoking cessation and alcohol and marijuana dependence.[65] | |

## TOPIC: GENETIC SCREENING
(as appropriate)

*Adolescents (13–18 years)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **For adolescents, if medical or psychosocial benefits of a genetic test will not accrue until adulthood (eg, for carrier status or adult-onset diseases), testing generally should be deferred until adulthood or until the adolescent has developed mature decision-making capacities. (Qualified)** | | ACOG: If medical or psychosocial benefits of a genetic test will not accrue until adulthood, as in the case of carrier status or adult-onset diseases, genetic testing generally should be deferred.[66]<br>AAP/ACMGG: Genetic testing for adult-onset conditions generally should be deferred until adulthood or until an adolescent interested in testing has developed mature decision-making capacities. It is inappropriate to test for late-onset disorders when genetic information has not been shown to reduce morbidity and mortality through interventions initiated in childhood. Routine carrier testing in minors is not supported when such testing does not provide health benefits in childhood.[67] | |

## TOPIC: HEPATITIS B SCREENING

*Adolescents and Adults (all ages)*
*(See also Immunizations)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Routine screening of the general population for chronic hepatitis B infection is not recommended. (Strong)** | USPSTF: Recommends against routinely screening the general asymptomatic population for chronic hepatitis B virus infection (Grade D).[68] | | |
| **Screening pregnant women for hepatitis B infection is recommended at the first prenatal visit. (Strong)** | USPSTF: Recommends screening pregnant women for hepatitis B infection at their first prenatal visit (Grade A).[69] | ACOG: Recommends routine prenatal screening of all pregnant women by hepatitis B surface antigen (HBsAg) testing (Level A).[70] | |

## TOPIC: HEPATITIS C SCREENING

*Adolescents and Adults (all ages)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Screening for hepatitis C virus (HCV) infection is recommended for women at high risk of infection. (Strong)**<br>**One-time screening for HCV infection should be offered to women born between 1945 and 1965. (Strong)** | USPSTF: Recommends screening for HCV infection in persons at high risk of infection. Recommends offering one-time screening for HCV infection to adults born between 1945 and 1965 (Grade B).[71] | AAFP: Recommends screening for HCV infection in persons at high risk of infection. Recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.[72]<br>ACOG: Recommends one-time testing for persons born from 1945 through 1965 who are unaware of their infection status.[2]<br>CDC: Adults born during 1945 through 1965 should be tested once for HCV infection without prior ascertainment of HCV risk factors. Recommends routine testing of asymptomatic persons at high risk of HCV infection.[73, 74]<br>PCHHC: Recommends screening for high-risk women. Women who test positive for hepatitis C and desire pregnancy should be counseled regarding the uncertain infectivity, the link between viral load and neonatal transmission, the importance of avoiding hepatotoxic drugs, and the risk of chronic liver disease.[75] | |

## TOPIC: IMMUNIZATIONS

*Adolescents and Adults (all ages)*
*(See also Cervical Cancer Screening and Prevention, Hepatitis B Screening, Preconception/Interconception Care)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Immunization is recommended according to the schedule and protocols outlined by ACIP. (Strong)** | ACIP: Recommends routine vaccines for children, adolescents, and adults according to its published immunization schedule.[76, 77] | | Recommend following ACIP guidelines for all immunizations. |

## TOPIC: INJURY PREVENTION

*Adolescents (13–18 years)*
*(See also Alcohol Misuse, Domestic and Intimate Partner Violence, Drug Use, Tobacco Use)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Discussion of injury prevention is recommended as part of every well-child visit. Adolescent counseling should be part of a broader discussion of healthy lifestyle choices, especially the avoidance of alcohol, tobacco, or other drug use. (Strong)** | USPSTF: There is insufficient evidence to assess the incremental benefit, beyond the efficacy of legislation and community-based interventions, of counseling in the primary care setting in improving rates of proper use of motor vehicle occupant restraints (child safety seats, booster seats, and lap-and-shoulder belts).[78] | AAP: Integrate counseling about preventing unintentional injury into every well-child visit. Adolescent counseling should be part of a broader discussion of healthy lifestyle choices, especially the avoidance of alcohol, tobacco, or other drug use.[79] | Recommend incorporating AAP guideline. |

## TOPIC: MENTAL HEALTH AND PSYCHOSOCIAL ISSUES/ SUICIDE/BEHAVIORAL ASSESSMENT

*Adolescents (13–18 years)*
*(See also Depression, Domestic and Intimate Partner Violence, Preconception/Interconception Care)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Annual screening of all adolescents for mental health disorders is recommended. (Strong)** | | AAP: Recommends annual screening for depression, suicide, and mental health. Surveillance at yearly health supervision visits: continuous monitoring of a child's developmental and behavioral status. May include history-taking and use of structured parent questionnaires.[6]<br>ACOG: Assess and provide health guidance on psychosocial development annually.[8] Recommends psychosocial evaluation for suicide; depressive symptoms; interpersonal and family relationships; sexual orientation and gender identity; personal goal development; behavioral and learning disorders; emotional, physical, and sexual abuse by family or partner; school experience; peer relationships; acquaintance rape prevention; and bullying.[2] | During annual preventive care visits, all adolescents should be screened for any mental health disorder by asking questions (such as those found in Bright Futures, Third Edition) that address depressive symptoms; interpersonal and family relationships; sexual orientation and gender identity; personal goal development; behavioral and learning disorders; emotional, physical, and sexual abuse by family or partner; school experience; peer relationships; acquaintance rape prevention; and bullying. |
| **Annual assessment for emotions and behaviors that indicate recurrent or severe depression and thoughts of killing or harming themselves is recommended. (Strong)** | | ACOG: Ask annually about emotions and behaviors that indicate recurrent or severe depression and thoughts of killing or harming themselves.[8] | |

## TOPIC: METABOLIC SYNDROME

*Adolescents (13–18 years)*
*(See also Diabetes, Obesity)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Screening for dyslipidemia is recommended once in late adolescence for all patients regardless of risk factors. (Strong)**<br>**Screening for dyslipidemia and hyperglycemia is recommended for patients with elevated BMI. Provide or refer patients to counseling about appropriate lifestyle modifications, medical treatment, or both. (Strong)** | USPSTF: Screen children aged 6 years and older for obesity and offer or refer to comprehensive, intensive behavioral interventions to promote improvement in weight status (Grade B).[80] | AAP: Assess BMI and screen for dyslipidemia. Screening for dyslipidemia is recommended once in late adolescence for all patients regardless of risk factors.[81] | Screen patients with elevated BMI for dyslipidemia and hyperglycemia. |

## TOPIC: NEURAL TUBE DEFECTS

*All Women of Reproductive Capacity*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Counsel all women planning or capable of pregnancy to take a daily supplement containing 0.4–0.8 mg (400–800 micrograms) of folic acid. The recommended dose should be increased to 4 mg per day in those taking anticonvulsant medications or who have a personal history of neural tube defects or who have delivered a baby affected by neural tube defects in an earlier pregnancy. (Strong)** | USPSTF, CDC: Recommend that all women planning or capable of pregnancy take a daily supplement containing 0.4–0.8 mg (400–800 micrograms) of folic acid.[82, 83] | AAP, AAFP, HMHB, March of Dimes: All women planning or capable of pregnancy should take a daily supplement containing 0.4–0.8 mg (400–800 micrograms) of folic acid. Increase to 4 mg in patients who have delivered a baby with neural tube defects, a history of neural tube defects herself, or taking anticonvulsant medications.[84, 85, 86, 87] | Adopt the evidence-informed guideline and recommend increased levels for patients at high risk. |

## TOPIC: OBESITY

*Adolescents (13–18 years)*
*(See also Diet, Fitness, Nutrition; Preconception/Interconception Care)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Routine weight assessment using BMI calculation is recommended. Results should be explained to the patient. For those with BMI greater than 30, provide or refer patients to intensive multicomponent behavioral interventions. (Strong)** | USPSTF: Recommends screening all adults for obesity. Clinicians should offer or refer patients with a BMI of 30 or higher to intensive, multicomponent behavioral interventions (Grade B).[80] | ACOG: Screen annually for obesity and overweight with BMI for age percentile, ask about body image, eating patterns, activity levels, and sedentary behavior.[8]<br>AAP: For overweight and obese adolescents, choose interventions according to the patient's age, BMI, weight goals, and health risks. AAP interventions are categorized as prevention counseling; Stage 1, Prevention Plus; Stage 2, Structured Weight Management; Stage 3, Comprehensive Multidisciplinary Intervention; and Stage 4, Tertiary Care Intervention.[88, 89] | The USPSTF approach is reasonable. At the very least, BMI should be calculated and some counseling should take place recommending solutions that are available locally. |

## TOPIC: ORAL HYGIENE

*Adolescents (13–18 years)*
*(See also Tobacco Use)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Fluoride supplementation should be recommended for adolescents up to age 16 years who live in areas with inadequate fluoride in water supplies. (Strong)** | USPSTF: Recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride (Grade B).[90] The evidence is insufficient to recommend for or against routine risk assessment of preschool children by primary care clinicians for the prevention of dental disease (Grade I).[90] | AAFP: For children aged 6 months to 16 years, fluoride supplementation is recommended to prevent dental caries in areas with inadequate fluoride in the water supply.[91]<br>ACOG: Counsel on fluoride supplementation and dental hygiene.[2]<br>AAP: Recommends oral health risk assessment. Dietary counseling for optimal oral health should be an intrinsic component of general health counseling. Administration of all fluoride modalities should be based on individual's caries risk. Supervised use of fluoride toothpaste is recommended for all children with teeth. The application of fluoride varnish by the medical practitioner is appropriate for patients with significant risk of dental caries who are unable to establish a dental home.[92] | Caries risk assessment is not supported by the literature, and no reliable risk assessment tool exists. Oral health risk assessment could conceivably include asking about smoking (oral cancer risk). |

## TOPIC: PELVIC EXAMINATION

*Adolescents (13–20 years)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Internal and speculum examinations should be reserved for symptomatic patients or those with specific indications (eg, intrauterine device placement) and need not be part of the well-woman visit in this age group. (Strong)**<br>**An external examination is an appropriate component of the well-woman visit in this age group at some point in the adolescent's development. (Strong)** | | ACOG: Recommends pelvic examinations be performed only when indicated by the medical history for patients younger than age 21 years. An "external-only" genital examination can provide the health care provider with the opportunity to evaluate the patient for normal external genital anatomy; issues of personal hygiene; and abnormalities of the vulva, introitus, and perineum that might require further investigation.[2]<br>AAP: Examination of the external genitalia should be included as part of the annual comprehensive physical examination of children and adolescents of all ages. Routinely explaining and including this examination normalizes the experience rather than setting it apart as something that is only performed as an exception. Most adolescents do not need an internal examination involving a speculum or bimanual examination. More extensive examination, which may include internal or speculum examination, is appropriate in the primary care setting for patients with persistent vaginal discharge, dysuria or urinary tract symptoms in a sexually active female, dysmenorrhea unresponsive to nonsteroidal inflammatory drugs, amenorrhea, abnormal vaginal bleeding, lower abdominal pain, suspected or reported rape or sexual abuse, or pregnancy. It is also appropriate as part of contraceptive counseling about use of an intrauterine device or diaphragm and in conjunction with a Pap test.[93] | |

## TOPIC: PIERCING AND TATTOOING

*Adolescents (13–18 years)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Annual evaluation and counseling adolescents about concerns associated with piercing and tattooing is recommended. (Strong)** | | ACOG: Recommends annual evaluation and counseling. Educate adolescents about concerns (eg, infections, scars, allergies, permanence of body art) associated with piercing and tattooing.[8]<br>AAPD: Provide anticipatory guidance and counseling on intraoral and oral piercing beginning at age 12 years or older annually.[94] | |

## TOPIC: PRECONCEPTION/INTERCONCEPTION CARE

*All Women of Reproductive Capacity*
*(See also Alcohol Misuse; Contraception, STIs, and Reproductive Health; Depression; Diabetes; Diabetes Postpartum; Mental Health and Psychosocial Issues/Suicide/Behavioral Assessment; Sexual Health; Tobacco Use)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Risk assessment, education, and health promotion counseling, based on the individual woman's desire for pregnancy, are recommended for all women to prevent unintended pregnancy, reduce risks, and improve pregnancy outcomes. (Strong)** | IOM: Provide evidence-based tests, procedures, and screening for nonpregnant women to optimize reproductive outcomes and prevent or optimize treatments for chronic conditions as well as topics for counseling and guidance for preconception health.[20]<br>IOM, CDC: Ensure access to the full range of FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity.[20, 34] | ACOG, AAP, PCCHC: Counsel patients about preventing unwanted and unintended pregnancy by postponing sexual involvement or using contraceptive options, including emergency contraception.[10, 95] | |
| **Postpartum screening and development of a plan for continuing care are recommended for women with risks identified in pregnancy that have implications for subsequent pregnancies, as well as for chronic disease development (eg, pregnancy-induced hypertension, gestational diabetes mellitus) or management (eg, clotting disorders, hepatitis). (Strong)** | IOM: Obtain a history of pregnancy complications, including preeclampsia, gestational hypertension, and gestational diabetes mellitus, from all women who have had at least one pregnancy.[20]<br>CDC: Safety, efficacy, availability, and acceptability should be considered by women, men, or couples when choosing the most appropriate contraceptive method. Voluntary informed choice of contraceptive methods is an essential guiding principle, and contraceptive counseling may contribute to the successful use of contraceptives. Assessment of the safety of a given contraceptive method for a person with a particular medical condition or characteristic should be included in counseling.[45] | AHA: Health care professionals who meet women for the first time later in their lives (ie, after their reproductive years) should take a careful and detailed history of pregnancy complications with focused questions about a history of gestational diabetes mellitus, preeclampsia, preterm birth, or birth of an infant who was small for gestational age.[96]<br>AHA/ASA: Because of the increased risk of future hypertension and stroke 1–30 years after delivery in women with a history of preeclampsia (Level of Evidence B), it is reasonable to (1) consider evaluating all women starting starting 6 months to 1 year postpartum, as well as those who are past childbearing age, for a history of preeclampsia/eclampsia and document their history of preeclampsia/eclampsia as a risk factor, and (2) evaluate and treat for cardiovascular risk factors, including hypertension, obesity, smoking, and dyslipidemia (Class IIa; Level of Evidence C).[97] | |
| **Postpartum screening, follow-up, and development of a plan for continuing care are recommended for women with lifestyle behaviors (eg, use of tobacco, alcohol, or Illicit drugs) or mental health issues (eg, antepartum or postpartum depression) identified during pregnancy that increase health risks. (Strong)** | IOM, USPSTF: Clinicians should ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products (Grade A).[20, 98] Screening and behavioral counseling interventions are recommended to reduce alcohol misuse by adults, including nonpregnant and pregnant women, in primary care settings (Grade B).[5, 20]<br>PCHHC Initiative, USDHHS: Assess at least annually for alcohol use patterns and risky drinking behaviors and provide appropriate counseling; all women should be advised of the risks alcohol exposure poses to the embryo and fetus and that no safe level of alcohol consumption during pregnancy has been established (PCHHC AIII).[10, 99] Assess for tobacco use at each encounter with the health care system. Women who smoke should be counseled, using the 5 A's, to limit exposure. (PCHHC; A II-2) (USDHHS/PHS: Level A for screening, B and C for interventions)[10, 100]<br>IOM: Screen for suicide ideation and postpartum depression in women who are pregnant or who have recently given birth.[20] | | |

## TOPIC: SEXUAL HEALTH

*Adolescents (13–18 years)*
*(See also Contraception, STIs, and Reproductive Health)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Providers should offer the opportunity for respectful and open dialogue about sexual health and sexuality that includes sexual orientation, gender identity, and sexual dysfunction at every comprehensive health visit. (Qualified)** | | | Open and respectful dialogue by health care providers is recommended. Although adolescents often want this dialogue, providers are reluctant to discuss sexual health with adolescents beyond advising patients to avoid unplanned pregnancy and STIs.[101]<br>A holistic approach with adolescents to sexual health that includes discussion of desire and relationships may increase healthy sexual behavior.[102] Sexuality is a normal and healthy part of adolescent development.[103]<br>Interventions to improve the quality and availability of reproductive health services should be targeted toward obstetrician–gynecologists and family practitioners.[39] |

## TOPIC: SKIN CANCER

*Adolescents (13–18 years)*
*(See also Contraception, STIs, and Reproductive Health)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Counseling adolescents about minimizing their exposure to ultraviolet radiation is recommended to reduce risk of skin cancer. (Strong)** | USPSTF: Recommends counseling children, adolescents, and young adults aged 10–24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk of skin cancer (Grade B).[104] | AAFP: Counsel children, adolescents and young adults (10–24 years) who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk of skin cancer (Grade B).[105]<br>AAP: Incorporate advice about ultraviolet radiation exposure into health-supervision practices for all children, especially for children at high risk of developing skin cancer: children with light skin; those with nevi, freckling, or both; and those with a family history of melanoma. Aim to incorporate ultraviolet radiation exposure advice into at least one health maintenance visit per year, beginning in infancy. Because melanoma occurs in teenagers and is a common cancer among young adults, clinicians caring for these groups should include a skin examination as part of a complete physical examination.[106]<br>ACOG: Counsel about skin exposure to ultraviolet rays.[2] | |
| **Adolescents should be encouraged to use sunscreen regularly and avoid artificial tanning. (Strong)** | | ACOG: Encourage regular use of sunscreen and avoidance of artificial tanning.[8] | |

## TOPIC: TOBACCO USE

*Adolescents (13–18 years)*
*(See also Oral Hygiene)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Providing annual education or brief counseling to prevent initiation of tobacco use is recommended. (Strong)**<br>**Screening annually for tobacco use and tobacco smoke exposure is recommended. For those who use tobacco products, encourage tobacco use cessation and provide cessation strategies. (Strong)**<br>**Provide effective interventions for treating tobacco use and dependence among adolescents. (Strong)** | USPSTF: Recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents (Grade B).[98] | AAFP: Strongly recommends counseling to smoking parents with children at home regarding the harmful effects of smoking on children's health.[107] Effectiveness of physician's advice and counseling in this area is uncertain; avoidance of tobacco products by children and adolescents is desirable.[108]<br>AAP: Screen annually for tobacco use and tobacco smoke exposure, encourage tobacco use cessation, and provide tobacco use cessation strategies and resources at most visits.[6]<br>ACOG: Ask about use of tobacco products.[8] | |
| | | AAP: Counseling should be developmentally appropriate and relevant across various age groups.[109]<br>ACOG: Recommends annual screening for tobacco use and evaluation and counseling, but the intervals at which such interventions should take place are not specified.[2]<br>PCHHC: Assess for tobacco use at each encounter with the health care system; women who smoke should be counseled, using the 5 As, to limit exposure (A II-2).[10] All women of childbearing age should be screened for tobacco use. Brief interventions should be provided to all tobacco users and should include brief counseling that describes the benefits of not smoking before, during, and after pregnancy; discussion of medication; and referral for more intensive services (individual, group, or telephone counseling) if the woman is willing to use these services. For pregnant women, augmented counseling interventions should be used (A I-a).[10] | |

## TOPIC: VISUAL ACUITY/GLAUCOMA

*Adolescents (13–18 years)*

| Final WWTF Recommendation | Evidence Based | Evidence Informed | Uniform Expert Agreement |
|---|---|---|---|
| **Screening for visual acuity is recommended twice: once in early adolescence (younger than 15 years) and once in late adolescence (15–18 years). Refer patients with any abnormality or suspicion of abnormality to an optometrist or ophthalmologist. (Qualified)** | | AAP: Screen for visual acuity once per year for ages 3–6, 8, 10, 12, 15, and 18 years. Screening should take place during other health supervision visits based on risk assessment or any concern on the part of the families or the child.[6] | Visual acuity screening should be performed once a year at ages 15 years and 18 years, if screening was performed at age 12 years. If no screening was performed at age 12 years, then screening should take place when the adolescent is seen at age 13 years or 14 years, then again at ages 15 years and 18 years. Any abnormality or suspicion of abnormality should be referred to an optometrist or ophthalmologist. |

**Abbreviations:** AAFP, American Academy of Family Physicians; AAP, American Academy of Pediatrics; ACIP, Advisory Committee on Immunization Practices; ACMGG, American College of Medical Genetics and Genomics; ACNM, American College of Nurse-Midwives; ACOG, American College of Obstetricians and Gynecologists; ACS, American Cancer Society; ACSP, American Society for Clinical Pathology; AHA, American Heart Association; AHRQ, Agency for Healthcare Research and Quality; ASA, American Stroke Association; ASCCP, American Society for Colposcopy and Cervical Pathology; BMI, body mass index; CDC, Centers for Disease Control and Prevention; FDA, Food and Drug Administration; HIV, human immunodeficiency virus; HPV, human papillomavirus infection; IOM, Institute of Medicine; NCQA, National Committee for Quality Assurance; NIAAA, National Institute on Alcohol Abuse and Alcoholism; PCHHC, Preconception Health and Health Care; PHS, U.S. Public Health Service; STIs, sexually transmitted infections; USDHHS, United States Department of Health and Human Services; USPSTF, United States Preventive Services Task Force; WWTF, Well Woman Task Force.

***Some references cited have been updated or archived since the Task Force meeting and, therefore, are for historical purposes only.***

## References

[1] Well-woman visit.  Committee Opinion No. 534. American College of Obstetricians and Gynecologists. Obstet Gynecol 2012;120:421-4.

***PMID: 22825111.***

[2] American College of Obstetricians and Gynecologists. Well-woman recommendations. Washington, DC: American College of Obstetricians and Gynecologists; 2015. Available at: http://www.acog.org/About-ACOG/ACOG-Departments/Annual-Womens-Health-Care/Well-Woman-Recommendations. Retrieved March 12, 2015.

[3] American College of Obstetricians and Gynecologists. Guidelines for women's health care. 4th ed. Washington, DC: American College of Obstetricians and Gynecologists; 2014.

[4] American Academy of Pediatrics. Recommendations for preventive pediatric health care. Elk Grove Village (IL): AAP; 2014. Available at: https://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf. Retrieved March 12, 2015.

[5] Moyer VA. Screening and behavioral counseling interventions in primary care to reduce alcohol misuse: U.S. preventive services task force recommendation statement. U.S. Preventive Services Task Force. Ann Intern Med 2013;159:210-8.

***PMID: 23698791.***

[6] Tanski S, Garfunkel LC, Duncan PM, Weitzman M, editors. Performing preventive services: A bright futures handbook. Elk Grove Village (IL): American Academy of Pediatrics; 2010. Available at: http://brightfutures.aap.org/continuing_education.html. Retrieved March 30, 2015.

[7] Kokotailo PK. Alcohol use by youth and adolescents: a pediatric concern. Committee on Substance Abuse. Pediatrics 2010;125:1078-87.

***PMID: 20385640***.

[8] American College of Obstetricians and Gynecologists. Guidelines for adolescent health care [CD-ROM]. 2nd ed. Washington, DC: American College of Obstetricians and Gynecologists; 2011.

[9] At-risk drinking and alcohol dependence: obstetric and gynecologic implications. Committee Opinion No. 496. American College of Obstetricians and Gynecologists. Obstet Gynecol 2011;118:383-8.

***PMID: 21775870.***

[10] Jack BW, Atrash H, Coonrod DV, Moos MK, O'Donnell J, Johnson K. The clinical content of preconception care: an overview and preparation of this supplement. Am J Obstet Gynecol 2008;199:S266-79.

***PMID: 19081421.***

[11] American Academy of Family Physicians. Alcohol misuse: clinical preventive service recommendation. Leawood (KS): AAFP; 2015. Available at: http://www.aafp.org/patient-care/clinical-recommendations/all/alcohol-misuse.html. Retrieved March 5, 2015.

[12] Centers for Disease Control and Prevention. Binge drinking: a serious, under-recognized problem among women and girls. CDC Vital signs. Atlanta (GA): CDC; 2013. Available at:  http://www.cdc.gov/vitalsigns/pdf/2013-01-vitalsigns.pdf. Retrieved March 12, 2015.

[13] National Institute on Alcohol Abuse and Alcoholism. Alcohol screening and brief intervention for youth: a practitioner's guide. Bethesda (MD): NIAAA; 2011. Available at: http://pubs.niaaa.nih.gov/publications/Practitioner/YouthGuide/YouthGuide.pdf. Retrieved March 30, 2015.

[14] U.S. Preventive Services Task Force. Iron deficiency anemia: screening. Rockville (MD): USPSTF; 2006. Available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsiron.htm. Retrieved March 30, 2015.

[15] Screening for asymptomatic bacteriuria in adults: U.S. Preventive Services Task Force reaffirmation recommendation statement. U.S. Preventive Services Task Force. Ann Intern Med 2008;149:43-7.

***PMID: 18591636.***

[16] American Academy of Family Physicians. Asymptomatic bacteriuria: clinical preventive service recommendation. Leawood (KS): AAFP; 2015. Available at: http://www.aafp.org/patient-care/clinical-recommendations/all/bacteriuria.html. Retrieved March 5, 2015.

[17] Screening for high blood pressure: U.S. Preventive Services Task Force reaffirmation recommendation statement. U.S. Preventive Services Task Force. Ann Intern Med 2007;147:783-6.

***PMID: 18056662.***

[18] Moyer VA. Screening for primary hypertension in children and adolescents: U.S. Preventive Services Task Force recommendation statement. U.S. Preventive Services Task Force. Pediatrics 2013;132:907-14.

***PMID: 24101758.***

[19] American Academy of Family Physicians. Summary of recommendations for clinical preventive services. Leawood (KS): AAFP; 2012. Available at: http://www.aafp.org/dam/AAFP/documents/patient_care/clinical_recommendations/October2012SCPS.pdf. Retrieved June 29, 2015.

[20] Committee on Preventive Services for Women, editor. Clinical preventive services for women: Closing the gaps. Washington, DC: Institute of Medicine; 2011. Available at: http://www.nap.edu/download.php?record_id=13181. Retrieved March 5, 2015.

[21] Primary care interventions to promote breastfeeding: U.S. Preventive Services Task Force recommendation statement. U.S. Preventive Services Task Force. Ann Intern Med 2008;149:560-4.

***PMID: 18936503.***

[22] Breastfeeding and the use of human milk. Section on Breastfeeding. Pediatrics 2012;129:e827-41.

***PMID: 22371471.***

[23] American College of Nurse Midwives. Breastfeeding. Position statement. Silver Spring (MD): ACNM; 2011. Available at: http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000248/Breastfeeding%20statement%20May%202011.pdf. Retrieved March 12, 2015.

[24] American Academy of Family Physicians. Breastfeeding: clinical preventive service recommendation. Leawood (KS): AAFP; 2015. Available at: http://www.aafp.org/patient-care/clinical-recommendations/all/breastfeeding.html. Retrieved March 5, 2015.

[25] Moyer VA. Screening for cervical cancer: U.S. Preventive Services Task Force recommendation statement. U.S. Preventive Services Task Force [published erratum appears in Ann Intern Med 2013;158:852]. Ann Intern Med 2012;156:880-91, W312.

***PMID: 22711081.***

[26] Saslow D, Solomon D, Lawson HW, Killackey M, Kulasingam SL, Cain J, et al. American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology screening guidelines for the prevention and early detection of cervical cancer. ACS-ASCCP-ASCP Cervical Cancer Guideline Committee. CA Cancer J Clin 2012;62:147-72.

***PMID: 22422631.***

[27] Screening for cervical cancer. Practice Bulletin No. 131. American College of Obstetricians and Gynecologists. Obstet Gynecol 2012;120:1222-38.

***PMID: 23090560.***

[28] American Academy of Family Physicians. Cervical cancer: clinical preventive service recommendation. Leawood (KS): AAFP; 2015. Available at: http://www.aafp.org/patient-care/clinical-recommendations/all/cervical-cancer.html. Retrieved February 9, 2015.

[29] Centers for Disease Control and Prevention. Human papillomavirus (HPV) ACIP vaccine recommendations. Atlanta (GA): CDC; 2014. Available at: http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hpv.html. Retrieved March 12, 2015.

[30] Human papillomavirus vaccination. Committee Opinion No. 588. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;123:712-8.

***PMID: 24553168.***

[31] American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, Centers for Disease Control and Prevention, Immunization Action Coalition. Give a strong recommendation for HPV vaccine to increase uptake! Leawood (KS): AAFP; 2014. Available at: http://www.aafp.org/dam/AAFP/documents/patient_care/immunizations/hpv-recommendation-letter.pdf. Retrieved March 12, 2015.

[32] Association of Women's Health, Obstetric & Neonatal Nursing. HPV vaccination for the prevention of cervical cancer. J Obstet Gynecol Neonatal Nurs 2010;39:129-30.

***PMID: 20040016.***

[33] Masur H, Brooks JT, Benson CA, Holmes KK, Pau AK, Kaplan JE. Prevention and treatment of opportunistic infections in HIV-infected adults and adolescents: Updated Guidelines from the Centers for Disease Control and Prevention, National Institutes of Health, and HIV Medicine Association of the Infectious Diseases Society of America. National Institutes of Health, Centers for Disease Control and Prevention, and HIV Medicine Association of the Infectious Diseases Society of America. Clin Infect Dis 2014;58:1308-11.

***PMID: 24585567.***

[34] Gavin L, Moskosky S, Carter M, Curtis K, Glass E, Godfrey E, et al. Providing quality family planning services: Recommendations of CDC and the U.S. Office of Population Affairs. Centers for Disease Control and Prevention. MMWR Recomm Rep 2014;63:1-54.

***PMID: 24759690.***

[35] Emergency contraception. Practice Bulletin No. 112. American College of Obstetricians and Gynecologists; Obstet Gynecol 2010;115:1100-9.

***PMID: 20410799.***

[36] The initial reproductive health visit.  Committee Opinion No. 598.  American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;123:1143-7.

***PMID: 24785880.***

[37] Blythe MJ, Diaz A. Contraception and adolescents. American Academy of Pediatrics Committee on Adolescence. Pediatrics 2007;120:1135-48.

***PMID: 17974753.***

[38] Promoting healthy sexual development and sexuality. In: Hagan JF, Shaw JS, Duncan PM, editors. Bright futures: guidelines for health supervision of infants, children, and adolescents. 3rd ed. Elk Grove Village (IL): AAP; 2008. p. 169-76. Available at: http://brightfutures.aap.org/pdfs/Guidelines_PDF/9-Promoting-Healthy-Sexual-Development.pdf. Retrieved March 12, 2015.

[39] Hoover KW, Tao G, Berman S, Kent CK. Utilization of health services in physician offices and outpatient clinics by adolescents and young women in the United States: implications for improving access to reproductive health services. J Adolesc Health 2010;46:324-30.

***PMID: 20307820.***

[40] Workowski KA, Berman S. Sexually transmitted diseases treatment guidelines, 2010. Centers for Disease Control and Prevention [published erratum appears in MMWR Morb Mortal Wkly Rep 2011;60:18]. MMWR Recomm Rep 2010;59:1-110.

***PMID: 21160459.***

[41] LeFevre ML. Screening for chlamydia and gonorrhea: U.S. Preventive Services Task Force recommendation statement. U.S. Preventive Services Task Force. Ann Intern Med 2014;161:902-10.

***PMID: 25243785.***

[42] Screening for chlamydial infection: U.S. Preventive Services Task Force recommendation statement. U.S. Preventive Services Task Force. Ann Intern Med 2007;147:128-34.

***PMID: 17576996.***

[43] LeFevre ML. Behavioral counseling interventions to prevent sexually transmitted infections: U.S. Preventive Services Task Force recommendation statement. U.S. Preventive Services Task Force. Ann Intern Med 2014;161:894-901.

***PMID: 25244227.***

[44] Screening for nonviral sexually transmitted infections in adolescents and young adults. Policy statement. American Academy of Pediatrics Committee on Adolescence, Society for Adolescent Health and Medicine. Pediatrics 2014;134:e302-11.

[45] U.S. Medical Eligibility Criteria for Contraceptive Use, 2010. Centers for Disease Control and Prevention. MMWR Recomm Rep 2010;59 (RR-4):1-86.

***PMID: 20559203.***

[46] Screening and treatment for major depressive disorder in children and adolescents: US Preventive Services Task Force Recommendation Statement. US Preventive Services Task Force [published erratum appears in Pediatrics 2009;123:1611]. Pediatrics 2009;123:1223-8.

***PMID: 19336383.***

[47] American Medical Association. Guidelines for adolescent preventive services (GAPS): Recommendations mongraph. Chicago (IL): AMA; 1997.

[48] Screening for depression in adults: U.S. preventive services task force recommendation statement. U.S. Preventive Services Task Force. Ann Intern Med 2009;151:784-92.

***PMID: 19949144.***

[49] American Academy of Family Physicians. Depression: clinical preventive service recommendation. Leawood (KS): AAFP; 2015. Available at: http://www.aafp.org/patient-care/clinical-recommendations/all/depression.html. Retrieved March 5, 2015.

[50] Association of Women's Health, Obstetric and Neonatal Nurses. The role of the nurse in postpartum mood and anxiety disorders. Washington, DC: AWHONN; 2008. Available at:  https://www.awhonn.org/awhonn/binary.content.do?name=Resources/Documents/pdf/5_PMAD.pdf. Retrieved March 30, 2015.

[51] American College of Nurse Midwives. Depression in women. Position statement. Silver Spring (MD): ACNM; 2013. Available at: http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000061/Depression%20in%20Women%20May%202013.pdf. Retrieved March 12, 2015.

[52] Screening for type 2 diabetes mellitus in adults: U.S. Preventive Services Task Force recommendation statement. U.S. Preventive Services Task Force [published erratum appears in Ann Intern Med 2008;149:147]. Ann Intern Med 2008;148:846-54.

***PMID: 18519930.***

[53] Executive summary: Standards of medical care in diabetes--2013. Diabetes Care 2013;36(suppl):S4-10.

***PMID: 23264424.***

[54] Moyer VA. Behavioral counseling interventions to promote a healthful diet and physical activity for cardiovascular disease prevention in adults: U.S. Preventive Services Task Force recommendation statement. U.S. Preventive Services Task Force. Ann Intern Med 2012;157:367-71.

***PMID: 22733153.***

[55] Maillet JO, Young EA. Position of the American Dietetic Association: nutrition education for health care professionals. J Am Diet Assoc 1998;98:343-6.

***PMID: 9508021.***

[56] Moyer VA. Primary care interventions to prevent child maltreatment: U.S. Preventive Services Task Force recommendation statement. U.S. Preventive Services Task Force. Ann Intern Med 2013;159:289-95.

***PMID: 23752681.***

[57] Moyer VA. Screening for intimate partner violence and abuse of elderly and vulnerable adults: U.S. preventive services task force recommendation statement. U.S. Preventive Services Task Force. Ann Intern Med 2013;158:478-86.

***PMID: 23338828.***

[58] Intimate partner violence. Committee Opinion No. 518. American College of Obstetricians and Gynecologists. Obstet Gynecol 2012;119:412-7.

***PMID: 22270317.***

[59] Chamberlain L, Levenson R. Addressing intimate partner violence, reproductive and sexual coercion: a guide for obstetric, gynecologic and reproductive health care settings. 2nd ed. Washington, DC: American College of Obstetricians and Gynecologists; San Francisco (CA): Futures Without Violence; 2012. Available at: http://www.futureswithoutviolence.org/userfiles/file/HealthCare/reproguidelines_low_res_FINAL.pdf. Retrieved April 1, 2015.

[60] Final recommendation statement: drug use, illicit: screening. U.S. Preventive Services Task Force. Rockville (MD): USPSTF; 2008. Available at: http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/drug-use-illicit-screening. Retrieved March 30, 2015.

[61] Floyd RL, Jack BW, Cefalo R, Atrash H, Mahoney J, Herron A, et al. The clinical content of preconception care: alcohol, tobacco, and illicit drug exposures. Am J Obstet Gynecol 2008;199:S333-9.

***PMID: 19081427.***

[62] American Academy of Family Physicians. Illicit drug use: clinical preventive service recommendation. Leawood (KS): AAFP; 2015. Available at: http://www.aafp.org/patient-care/clinical-recommendations/all/illicit-drug-use.html. Retrieved March 5, 2015.

[63] National Adolescent and Young Adult Health Information Center. Summary of recommended guidelines for clinical preventive services for young adults ages 18-26. San Francisco (CA): NAHIC; 2014. Available at: http://nahic.ucsf.edu/wp-content/uploads/2014/04/FINAL-Guidelines-Summary-4.171.pdf. Retrieved March 30, 2015.

[64] Michigan Quality Improvement Consortium. Screening, diagnosis and referral for substance use disorders. Michigan Quality Improvement Consortium Guideline. Southfield (MI): MQIC; 2013. Available at: http://www.mqic.org/pdf/mqic_screening_diagnosis_and_referral_for_substance_use_disorders_cpg.pdf. Retrieved March 30, 2015.

[65] National Committee for Quality Assurance. Summary table of measures, product lines and changes. HEDIS 2015. Washington, DC: NCQA; 201. Available at: http://www.ncqa.org/Portals/0/HEDISQM/Hedis2015/List_of_HEDIS_2015_Measures.pdf. Retrieved March 30, 2015.

[66] Hereditary breast and ovarian cancer syndrome. ACOG Practice Bulletin No. 103. American College of Obstetricians and Gynecologists. Obstet Gynecol 2009;113:957-66.

***PMID: 19305347.***

[67] Ethical and policy issues in genetic testing and screening of children. Committee on Bioethics, Committee on Genetics, American College of Medical Genetics, Genomics Social Committee, Ethical Committee, and Legal Issues Committee. Pediatrics 2013;131:620-2.

***PMID: 23428972.***

[68] LeFevre ML. Screening for hepatitis B virus infection in nonpregnant adolescents and adults: U.S. Preventive Services Task Force recommendation statement. U.S. Preventive Services Task Force. Ann Intern Med 2014;161:58-66.

***PMID: 24863637.***

[69] Screening for hepatitis B virus infection in pregnancy: U.S. Preventive Services Task Force reaffirmation recommendation statement. U.S. Preventive Services Task Force. Ann Intern Med 2009;150:869-73, W154.

***PMID: 19528565***.

[70] Viral hepatitis in pregnancy. ACOG Practice Bulletin No. 86. American College of Obstetricians and Gynecologists. Obstet Gynecol 2007;110:941-56.

***PMID: 1790604***3.

[71] Moyer VA. Screening for hepatitis C virus infection in adults: U.S. Preventive Services Task Force recommendation statement. U.S. Preventive Services Task Force. Ann Intern Med 2013;159:349-57.

***PMID: 23798026.***

[72] American Academy of Family Physicians. Hepatitis: clinical preventive service recommendation. Leawood (KS): AAFP; 2015. Available at: http://www.aafp.org/patient-care/clinical-recommendations/all/hepatitis.html. Retrieved March 5, 2015.

[73] Recommendations for prevention and control of hepatitis C virus (HCV) infection and HCV-related chronic disease. Centers for Disease Control and Prevention. MMWR Recomm Rep 1998;47:1-39.

***PMID: 9790221.***

[74] Centers for Disease Control and Prevention. Testing recommendations for Hepatitis C virus infection. Atlanta (GA): CDC; 2014. Available at: http://www.cdc.gov/hepatitis/HCV/GuidelinesC.htm. Retrieved March 12, 2015.

[75] Floyd RL, Johnson KA, Owens JR, Verbiest S, Moore CA, Boyle C. A national action plan for promoting preconception health and health care in the United States (2012-2014). J Womens Health (Larchmt) 2013;22:797-802.

***PMID: 23944970.***

[76] Centers for Disease Control and Prevention. Birth-18 years & "catch-up" immunization schedules: United States, 2015. Atlanta (GA): CDC; 2015. Available at: http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html. Retrieved March 12, 2015.

[77] Centers for Disease Control and Prevention. Adult immunization schedules, United States, 2015. Atlanta (GA): CDC; 2015. Available at: http://www.cdc.gov/vaccines/schedules/hcp/adult.html. Retrieved March 12, 2015.

[78] U.S. Preventive Services Task Force. Counseling about proper use of motor vehicle occupant restraints and avoidance of alcohol use while driving: U.S. Preventive Services Task Force recommendation statement. Ann Intern Med 2007;147:187-93.

***PMID: 17679707.***

[79] Gardner HG. Office-based counseling for unintentional injury prevention. American Academy of Pediatrics Committee on Injury, Violence, and Poison Prevention. Pediatrics 2007;119:202-6.

***PMID: 17200289.***

[80] Barton M. Screening for obesity in children and adolescents: US Preventive Services Task Force recommendation statement. U.S. Preventive Services Task Force. Pediatrics 2010;125:361-7.

***PMID: 20083515.***

[81] American Academy of Pediatrics. Bright futures medical screening reference table: adolescent visits. Bright futures tool and resource kit. Elk Grove Village (IL): AAP; 2010. p. 1-2. Available at: https://brightfutures.aap.org/pdfs/Other%203/D.Adol.MST.Adolescence.pdf. Retrieved March 12, 2015.

[82] Folic acid for the prevention of neural tube defects: U.S. Preventive Services Task Force recommendation statement. U.S. Preventive Services Task Force. Ann Intern Med 2009;150:626-31.

***PMID: 19414842***.

[83] Centers for Disease Control and Prevention. Preventing neural tube birth defects: a prevention model and resource guide. Atlanta (GA): CDC; 2009. Available at:  http://www.cdc.gov/ncbddd/orders/pdfs/09_202063-a_nash_neural-tube-bd-guide-final508.pdf. Retrieved March 12, 2015.

[84] Folic acid for the prevention of neural tube defects. American Academy of Pediatrics. Committee on Genetics. Pediatrics 1999;104:325-7.

***PMID: 10429019.***

[85] American Academy of Family Physicians. Neural tube defects: clinical preventive service recommendation. Leawood (KS): AAFP; 2015. Available at: http://www.aafp.org/patient-care/clinical-recommendations/all/neural-tube-defects.html. Retrieved February 9, 2015.

[86] National Healthy Mothers, Healthy Babies Coalition. National healthy mothers, healthy babies mother's day call to action [press release]. Alexandria (VA): HMHB; 2012. Available at: http://www.hmhb.org/press_release/mothers-day-call-to-action/. Retrieved March 30, 2015.

[87] March of Dimes. Birth defects. White Plains (NY): March of Dimes; 2012. Available at: http://www.marchofdimes.org/baby/neural-tube-defects.aspx. Retrieved March 30, 2015.

[88] Barlow SE, Expert Committee. Expert committee recommendations regarding the prevention, assessment, and treatment of child and adolescent overweight and obesity: summary report. Pediatrics 2007;120 (suppl):S164-92.

***PMID: 18055651.***

[89] Davis MM, Gance-Cleveland B, Hassink S, Johnson R, Paradis G, Resnicow K. Recommendations for prevention of childhood obesity. Pediatrics 2007;120 (suppl):S229-53.

***PMID: 18055653.***

[90] Moyer VA. Screening for and management of obesity in adults: U.S. Preventive Services Task Force recommendation statement. U.S. Preventive Services Task Force. Ann Intern Med 2012;157:373-8.

***PMID: 22733087.***

[91] American Academy of Family Physicians. Obesity: clinical preventive service recommendation. Leawood (KS): AAFP; 2015. Available at: http://www.aafp.org/patient-care/clinical-recommendations/all/obesity.html. Retrieved March 5, 2015.

[92] Preventive oral health intervention for pediatricians. Section on Pediatric Dentistry and Oral Health. Pediatrics 2008;122:1387-94.

***PMID: 19015205.***

[93] Braverman PK, Breech L, Committee on Adolescence. American Academy of Pediatrics. Clinical report--gynecologic examination for adolescents in the pediatric office setting. Pediatrics 2010;126:583-90.

***PMID: 20805151.***

[94] American Academy of Pediatric Dentistry. Guideline on periodicty of examination, preventive dental services, anticipatory guidance/counseling, and oral treatment for infants, children, and adolescents. In: 2014-15 Reference manual: definitions, oral health policies, and clinical guidelines. Chicago (IL): AAPD; 2014. p. 118-25. Available at: http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf. Retrieved March 5, 2015.

[95] American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Guidelines for perinatal care. 7th ed. Elk Grove Village (IL): Washington, DC: AAP; American College of Obstetricians and Gynecologists; 2012.

[96] Mosca L, Benjamin EJ, Berra K, Bezanson JL, Dolor RJ, Lloyd-Jones DM, et al. Effectiveness-based guidelines for the prevention of cardiovascular disease in women--2011 update: a guideline from the American Heart Association. American Heart Association [published erratum appears in J Am Coll Cardiol 2012;59:1663]. J Am Coll Cardiol 2011;57:1404-23.

***PMID: 21388771.***

[97] Bushnell C, McCullough LD, Awad IA, Chireau MV, Fedder WN, Furie KL, et al. Guidelines for the prevention of stroke in women: a statement for healthcare professionals from the American Heart Association/American Stroke Association. American Heart Association Stroke Council, Council on Cardiovascular and Stroke Nursing, Council on Clinical Cardiology, Council on Epidemiology and Prevention, Council for High Blood Pressure Research [published erratum appears in Stroke 2014;45:e214]. Stroke 2014;45:1545-88.

***PMID: 24503673.***

[98] Counseling and interventions to prevent tobacco use and tobacco-caused disease in adults and pregnant women: U.S. Preventive Services Task Force reaffirmation recommendation statement.  U.S. Preventive Services Task Force. Ann Intern Med. 2009 Apr 21;150(8):551-5.

***PMID: 19380855.***

[99] Carmona RH. Advisory on alcohol use in pregnancy. A 2005 message to women from the U.S. Surgeon General. Washington, DC: U.S. Surgeon General's Office; 2005. Available at: http://www.cdc.gov/ncbddd/fasd/documents/sg-advisory.pdf. Retrieved March 30, 2015.

[100] Fiore MC, Jaen CR, Baker TB, Bailey WC, Benowitz NL, Curry SJ, et al. Treating tobacco use and dependence: 2008 update. Clinical Practice Guideline. Rockville (MD): U.S. Department of Health and Human Services; 2008. Available at: http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/treating_tobacco_use08.pdf. Retrieved March 5, 2015.

[101] Satcher D. Addressing sexual health: looking back, looking forward. Public Health Rep 2013;128 (suppl):111-4.

***PMID: 23450892.***

[102] Douglas JM, Jr, Fenton KA. Understanding sexual health and its role in more effective prevention programs. Public Health Rep 2013;128 (suppl):1-4.

***PMID: 23450880.***

[103] Nystrom RJ, Duke JE, Victor B. Shifting the paradigm in Oregon from teen pregnancy prevention to youth sexual health. Public Health Rep 2013;128 (suppl):89-95.

***PMID: 23450889***.

[104] Moyer VA. Behavioral counseling to prevent skin cancer: U.S. Preventive Services Task Force recommendation statement. U.S. Preventive Services Task Force. Ann Intern Med 2012;157:59-65.

***PMID: 22751761.***

[105] American Academy of Family Physicians. Skin Cancer: clinical preventive service recommendation. Leawood (KS): AAFP; 2015. Available at: http://www.aafp.org/patient-care/clinical-recommendations/all/skin-cancer.html. Retrieved March 5, 2015.

[106] Balk SJ. Ultraviolet radiation: a hazard to children and adolescents. Council on Environmental Health and Section on Dermatology. Pediatrics 2011;127:588-97.

***PMID: 21357336.***

[107] American Academy of Family Physicians. Tobacco: preventing and treating nicotine dependence and tobacco use. Position Paper. Leawood (KS): AAFP; 2014. Available at:  http://www.aafp.org/about/policies/all/nicotine-tobacco-prevention.html. Retrieved March 12, 2015.

[108] American Academy of Family Physicians. Tobacco use. Clinical preventive service recommendation. Leawood (KS): AAFP; 2009. Available at: http://www.aafp.org/patient-care/clinical-recommendations/all/tobacco-use.html. Retrieved March 12, 2015.

[109] Sims TH; Committee on Substance Abuse. From the American Academy of Pediatrics: Technical report--Tobacco as a substance of abuse. Pediatrics. 2009 Nov;124(5):e1045-53. doi: 10.1542/peds.2009-2121. Epub 2009 Oct 19. PubMed PMID: 19841120.