



TOOL KIT FOR TEEN CARE
SECOND EDITION

PRIMARY AND PREVENTIVE
HEALTH CARE FOR
FEMALE ADOLESCENTS



THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

KEY POINTS

- The delivery of preventive services to adolescents differs from the delivery of preventive services to adults. An adolescent's particular developmental stage uniquely frames the constellation of recommended preventive services. Understanding the milestones and developmental stages of adolescence is essential to obstetrician–gynecologists and all other health care providers who treat adolescents.
- Adolescent girls should first visit an obstetrician–gynecologist between the ages of 13 years and 15 years, with subsequent annual visits. In some cases, this visit may be appropriate earlier, based on concerns of the parent(s). Care should be delivered according to the individual's stage of physical, sexual, psychologic, and cognitive development.
- The initial visit generally does not include a pelvic examination. A pelvic examination should be performed when indicated by the medical history (eg, pubertal aberrancy, abnormal bleeding or discharge, or abdominal or pelvic pain). If the patient has had sexual intercourse, screening for sexually transmitted diseases (STD) is appropriate, and the patient should have her first Pap test at age 21 years.
- Annual visits provide opportunities to offer health guidance; discuss normal development; provide screening and care for physical, emotional, and behavioral conditions; and review and update immunizations. A physical examination is not required at every visit but should be included at least once during early, middle, and late adolescence. Parents and caregivers should receive health guidance during these visits.
- Once young females begin menstruating, evaluation of the menstrual cycle should be included with an assessment of other vital signs so clinicians can emphasize the important role of menstrual patterns in reflecting overall health status. Severe cramping that does not respond to usual medical therapy could indicate endometriosis. Appropriate assessment is warranted.
- All adolescents should be screened annually for hypertension, eating disorders, tobacco use, alcohol and drug use, sexual activity, depression, abuse, sexual assault, and school performance. Those at risk for hyperlipidemia and adult coronary heart disease also should have their cholesterol levels checked.
- All sexually active adolescents should be screened annually for gonorrhea, chlamydia, and human immunodeficiency virus (HIV). Screening for trichomoniasis, syphilis, hepatitis B and hepatitis C, should be provided as indicated.

Adolescence is a time of transition from childhood to adulthood and is marked by a number of developmental milestones. For many, this transition is relatively smooth; for others, however, it may be a time of difficulty. Adolescent girls are confronted with numerous challenges, and the decisions they make can have both short- and long-term consequences for their health and well-being.

The primary health risks to adolescents are no longer the traditional medical causes of illness; rather, they are behavioral. These risks include a sedentary lifestyle; unhealthy nutritional habits; depression; cigarette smoking and alcohol use as well as illicit and prescription drug use; unsafe driving, including under the influence of alcohol; early initiation of sexual activity; and unprotected sexual activity. Most adolescents will engage in at least one health-jeopardizing behavior. Data from the 2007 Youth Risk Behavior Surveillance Report indicate that nearly 72% of all deaths among adolescents and young adults (aged 10–24 years) in 2007 resulted from four types of incidents: 1) motor vehicle crashes (30%), 2) other unintentional injuries (15%), 3) homicide (15%), or 4) suicide (12%) (1).

Guidance from a physician can greatly facilitate a young girl's healthy transition to adulthood. Physicians can provide preventive guidance to both parents and adolescents. They can screen for health-risk behaviors and diseases and provide office-based interventions or facilitate referral to an appropriate program or professional. In addition, they can either provide or refer patients for the necessary immunizations against infectious diseases. Obstetrician–gynecologists should make preventive services a greater component of their clinical practice. Because the obstetrician–gynecologist can function as either a primary care physician or a consultant specialist, it is important to determine whether the adolescent patient has a primary care provider. Girls in this age group may see a pediatrician, family medicine practitioner, or internist for primary care. If so, a collaborative relationship between health care providers should be established. The following outlined approach can help ensure that adolescents receive health services that are appropriate for their developmental status and behavioral risks.

FEMALE ADOLESCENT DEVELOPMENT

The delivery of preventive services to adolescents is unique and differs from the delivery of preventive services to adults. An adolescent's particular developmental stage uniquely frames the constellation of recommended preventive services. Furthermore, not all adolescents of the same age are at the same stage of development, so clinicians need to assess each adolescent's physical, sexual, psychosocial, and cognitive development. Understanding the milestones and developmental stages of adolescence is essential to obstetrician–gynecologists and all other health care providers who treat adolescents.





Sexual Development

Theharche, or breast budding, typically the first visible sign of female secondary sexual development, occurs for most young girls in North America at age 10 years, ranging from 8 years to 13 years of age. In African-American girls, it can occur as early as 6 years (2). On average, menarche occurs between ages 11–13 years, with regular ovulation established by approximately 20 cycles later. Once young females begin menstruating, evaluation of the menstrual cycle should be included with an assessment of other vital signs. By including this information with the other vital signs, clinicians emphasize the important role of menstrual patterns in reflecting overall health status. If a teen fails to show signs of breast development by age 13 years, she should be evaluated by her physician. Delays in onset of puberty may be familial or associated with low body weight, athletic training, eating disorders, or genetic and medical conditions.

With theharche, breast concerns may arise in the adolescent female and encompass an expansive array of topics. Clinicians who encounter adolescent patients with breast concerns should carefully assess their patients to avoid unnecessary diagnostic procedures and surgery (see ACOG Committee Opinion Number 350, Breast Concerns in the Adolescent).

Although endometriosis is thought of as a disease that affects adult women, it increasingly is being diagnosed in the adolescent population. Pediatricians, adolescent health care providers, and gynecologists should recognize that theharche and the presence of endogenous estrogen can be considered a developmental milestone and benchmark for consideration of adolescent endometriosis in young women with chronic pelvic pain (see ACOG Committee Opinion Number 310, Endometriosis in Adolescents).

Psychosocial and Cognitive Development

Adolescence is a prolonged period of transition during which a young individual's expanding horizons, self-discovery, and quest for independence lead to the formation of a separate and distinct identity (3). It is particularly challenging because the processes of physical, psychologic, and cognitive development occur on separate tracks, with different timetables, which rarely are synchronous. Thus, an obstetrician–gynecologist often will encounter a young girl who has matured physically but has not accomplished important psychologic and cognitive developmental tasks.

The adolescent often believes that she is different from others and, therefore, not liable to the risks that threaten her peers. In “real world” situations, it may be difficult for adolescents to use analytic processing as they make decisions, especially when they are under social–emotional pressure. Thus, the clinical approach to counseling a cognitively younger adolescent will differ from the approach taken with a cognitively older adolescent or an adult.

TIMING OF HEALTH CARE VISITS

Initial Visit

Obstetrician–gynecologists frequently are asked by adult patients at what age their adolescent daughters should visit an obstetrician–gynecologist. The first visit to the obstetrician–gynecologist for health guidance, screening, and the provision of preventive health care services should take place between the ages of 13 years and 15 years (4). The exact timing and scope of the initial visit to the obstetrician–gynecologist will depend on the individual and her physical and emotional development. In some cases, this visit may be appropriate earlier, based on concerns of the parent(s).

Parents or guardians (from this point forward, the term “parents” also will indicate guardians and other care providers) and adolescent females should be reassured that the initial visit at this age serves primarily to establish rapport between the obstetrician–gynecologist and the young woman. Generally, it does not include an internal pelvic examination, although examination of the breasts and external genitals for pubertal development may be appropriate. This visit is an ideal opportunity to discuss, with both parents and young patients, normal adolescent development and other concerns related to adolescence.

To provide optimum health care, physicians should discuss issues of confidentiality with both the adolescent and her parent(s). (See “Confidentiality in Adolescent Health Care” for more on confidentiality issues.) Confidentiality frequently is identified as a major obstacle to the delivery of health care services to adolescents. To overcome this barrier, physicians should initiate discussion of this topic, advise the adolescent patient and her parent(s) of relevant state and local statutes, and stress the importance of open communication among all parties.

The provision of additional services beyond guidance and screening should be based on the information obtained at this initial visit. If the patient has had sexual intercourse, screening for STDs is appropriate. Urine screening for gonorrhea and chlamydia should be performed unless there are indications for a pelvic examination (5). A pelvic examination should be performed in symptomatic individuals when indicated by the medical history (eg, pubertal aberrancy, abnormal bleeding or discharge, or abdominal or pelvic pain). The first Pap test should be done at age 21 years.

Annual Visits

Because adolescence is a time of transition and the potential for unhealthy behaviors and compromised health outcomes is significant, the initial consultation visit should be followed by annual preventive health care visits. Annual visits contribute to the formation of a trusting relationship between the adolescent patient and her obstetrician–gynecologist. This, in turn, eases the disclosure of high-risk behaviors and facilitates the early diagnosis of physical and emotional disorders. Such visits also enhance the physician’s credibility as a caring adult and, therefore, lend weight to recommen-

dations that promote good health. Finally, annual visits may enable the adolescent to assume increasingly greater responsibility for her health, safety, and well-being.

The proactive, annual preventive health care visit should focus on health guidance for both the patient and parent(s), including a discussion of normal adolescent development; screening for physical, emotional, and behavioral conditions; and a review and update of immunizations. Primary and preventive health care for adolescents should be based on the guidelines summarized in this document. Physicians should tailor the content of their health guidance, screening, and level of parental involvement to the unique requirements of each patient. A general physical examination is not required at every visit but should be performed at least once during early adolescence (ages 12–14 years), middle adolescence (ages 15–17 years), and late adolescence (ages 18–21 years). A pelvic examination is not required at every visit but should be performed when indicated by the medical history (eg, pubertal aberrancy, abnormal bleeding or discharge, or abdominal or pelvic pain). Assessment of internal genital structures (eg, ovarian pathology, müllerian anomalies) may be accomplished by ultrasonography if the clinician is concerned that a bimanual examination for a young teen may be difficult. A general physical examination, including a visual breast examination and external genital examination, may be performed because it allows assessment of secondary sexual development, reassurance, and education. A “teaching,” external-only genital examination can provide an opportunity to familiarize adolescents with normal anatomy, assess adequacy of hygiene, and allow the health care provider an opportunity to visualize the perineum for any anomalies. Guidelines for urine screening for gonorrhea and chlamydia, speculum examinations, and Pap tests are the same as those for the initial visit.

To help adolescents navigate the transition from childhood to adulthood, a number of organizations have formulated guidelines for adolescent preventive health care services. Guidelines for Adolescent Preventive Services (GAPS), developed by the American Medical Association in consultation with a national group of experts, including representatives from the American College of Obstetricians and Gynecologists (ACOG), is the primary source of the following recommendations (6). These recommendations form the basis for the adolescent section of the new revision of Bright Futures, the American Academy of Pediatrics’ guidelines for health care of infants, children, and adolescents (For more information go to: <http://brightfutures.aap.org/index.html>). The recommendations are grouped into three categories: 1) health guidance for parents and adolescents, 2) screening, and 3) immunization.

HEALTH GUIDANCE

Periodic health guidance for parents and adolescents is a critical component of primary and preventive health care. This is different from obtaining the medical history because it involves the counseling and discussion component of the health care visit. Health guidance provides an opportunity for physicians, adolescent patients, and their parents to address current and potential health care needs.

For the Parents

Parents and other adult caregivers should receive health guidance at least once during their child's early adolescence, once during middle adolescence, and preferably once during late adolescence. Such guidance can be provided either concurrent to the adolescent's visit or as a separate visit. Health guidance for parents includes information about the following areas:

- Normal adolescent development, including information about physical, sexual, and emotional development
- Signs and symptoms of common morbidities in adolescents, such as depression, anxiety, and substance abuse
- Physical and psychosocial benefits gained from maintaining a normal body weight through a healthy diet and regular exercise, including participation in sports, youth organizations, and other supervised extracurricular activities
- Parenting behaviors that promote healthy adolescent adjustments, including
 - Allowing increased autonomy and responsibility
 - Anticipating challenges to parental authority
 - Jointly establishing family rules and the consequences for breaking them and enforcing those rules and consequences
 - Enhancing self-esteem with praise and recognition of positive behaviors and achievements
 - Minimizing criticism
 - Respecting privacy
 - Spending time with the adolescent
- Ways to minimize potentially harmful behaviors by
 - Monitoring and managing the adolescent's use of motor vehicles and passenger responsibilities
 - Knowing where the adolescent is and setting up agreements to have them check in when they go out
 - Avoiding weapons in the home or ensuring that all family members follow strict safety procedures for both weapon storage and use
 - Removing weapons and potentially lethal medications from the home of a depressed or suicidal adolescent





- Monitoring the adolescent’s social and recreational activities, including tobacco, alcohol, and drug use and sexual behavior, particularly during early and middle adolescence
- Remaining involved in the adolescent’s use of her free time, including television and Internet usage, particularly during early and middle adolescence
- Monitoring choice of friends and peer relationships
- Recognizing the adolescent’s vulnerability in unequal relationships, such as those with older partners or when the partner is in a position of relative authority over the adolescent (7)
- Being aware that dating violence, regardless of partner age, is common among adolescents and may be hidden from parents
- Encouraging the regular use of sunscreen and avoiding artificial tanning

Additionally, it is important for parents to recognize the influential role of the media, particularly as a source of sexual information for adolescents. At an age when many girls experience a decrease in their self-esteem (8), youth-oriented media reinforce sexual stereotypes and emphasize physical appearances, often promoting unhealthy standards. Popular publications advise girls on attracting adolescent males with little or no information to help readers make healthy, safe, and responsible decisions. Such materials further contribute to the difficult choices that increasingly younger girls are forced to consider.

For the Adolescent

Adolescents should receive annual health guidance to promote a better understanding of their physical, psychosocial, and psychosexual development. Such guidance should emphasize health promotion and risk reduction strategies, such as avoiding behaviors that jeopardize their health or safety, being responsible for their health preservation, and early reporting of any signs or symptoms of concern, including irregular or missing menses. The importance of becoming actively involved in decisions regarding their own health care also should be stressed.

Screening provides an excellent opportunity to counsel adolescents about healthy lifestyles. Because of concerns regarding mutual trust, issues of confidentiality, and individual comfort levels when discussing sensitive topics, eliciting an accurate response from an adolescent can be difficult. It is important to frame questions using a strength-based perspective and to ensure that the adolescent appreciates that the physician is interested in her well-being as a unique individual. Often, repeated questioning over time is necessary to obtain accurate and complete information.

Health guidance for the adolescent should address diet and physical activity, healthy sexual development, and injury prevention as highlighted in the following list:

- Healthy body image and awareness of unhealthy media and social messages

- Eating patterns and dietary habits, including ways to achieve a healthy diet and safe weight management
- The benefits of physical activity and encouragement to regularly engage in safe physical activities
- Responsible, consensual sexual behavior, including counseling on the following topics:
 - Abstinence from sexual intercourse and information that this method is the most effective way to prevent pregnancy and STDs
 - Responsible sexual behavior for both adolescents who are and who are not currently sexually active
 - Effective use of contraception and condoms
 - Risk for STDs, including HIV, from vaginal, oral, and anal sex
 - The effectiveness of latex condoms in reducing the risk of pregnancy and STDs, including HIV infection
 - Human immunodeficiency virus transmission and the dangers of the disease
 - Reducing the risk of sexual victimization and acquaintance rape, including the role of alcohol and other drugs
 - Safe use of the Internet, e-mail, chat rooms and other electronic communications
 - Information on effective regular methods of contraception and emergency contraception, including the 24-hour, national toll-free hotline number 1-888-NOT-2-LATE
- Prevention of injuries, including discussions on the following topics:
 - Avoiding the use of alcohol or other substances
 - Avoiding driving a motor vehicle or other recreational vehicle if the adolescent has consumed alcohol or other substances
 - Avoiding riding in a car or other recreational vehicle if the driver has consumed alcohol or other substances
 - Encouraging adolescents and their parents to develop positive, nonpunitive agreements for picking up adolescents who have consumed alcohol or other substances
 - Educating adolescents about concerns associated with piercing and tattooing
 - Using safety devices, including seat belts and helmets
 - Using nonviolent conflict resolution
 - Avoiding the use of weapons

SCREENING

Screening for many of the following issues, such as sexual activity, depression, abuse, school performance, and tobacco, alcohol, and other drug use can be facilitated by use of a questionnaire as an alternative to direct interviewing. (For more information, see the “ACOG Adolescent Visit Record and ACOG Adolescent Visit and Parent Questionnaire.”)

Blood Pressure

All adolescents should be screened annually for hypertension according to the protocol developed by the National Heart, Lung, and Blood Institute Task Force on High Blood Pressure in Children and Adolescents (9). Although the incidence of hypertension in adolescence is low, early detection of elevated blood pressure and evaluation for hypertension risk factors may prevent later cardiovascular diseases.

Height is the single most important determinant of blood pressure in children and adolescents (9). By accounting for different levels of growth when evaluating blood pressure, a more precise classification can be made, thus avoiding misclassification of those adolescents at the extremes for normal growth (Fig. 1 and Fig. 2).

Cholesterol

To determine their risk for developing hyperlipidemia and adult coronary heart disease, adolescents should be screened by history using the following guidelines. Selected adolescents should undergo lipid testing according to the protocol developed by the Expert Panel on Blood Cholesterol in Children and Adolescents (10):

- Adolescents whose parents have a serum cholesterol level greater than 240 mg/dL should be screened for total blood cholesterol (nonfasting) at least once.
- Adolescents with either an unknown family history or risk factors for future cardiovascular disease (eg, smoking, hypertension, obesity, diabetes mellitus, and excessive consumption of dietary saturated fats and cholesterol) may be screened for total serum cholesterol level (nonfasting) at least once at the discretion of the physician.
- In adolescents with the previously mentioned risk factors and blood cholesterol values less than 170 mg/dL, the test should be repeated in 5 years. Those with values between 170 mg/dL and 199 mg/dL should have a repeat test. If the average value of the two tests is less than 170 mg/dL, the total blood cholesterol level should be reassessed within 5 years. A lipoprotein analysis (high-density lipoprotein and low-density lipoprotein) should be performed if the average cholesterol value from the two tests is 170 mg/dL or greater or if the result of the initial test was 200 mg/dL or greater.

BP Levels for Girls by Age and Height Percentile

Age (Years)	Blood Pressure Percentile	Systolic Blood Pressure (mm Hg) Percentile of Height							Diastolic Blood Pressure (mm Hg) Percentile of Height						
		5th	10th	25th	50th	75th	90th	95th	5th	10th	25th	50th	75th	90th	95th
13	50th	104	105	106	107	109	110	110	62	62	62	63	64	65	65
	90th	117	118	119	121	122	123	124	76	76	76	77	78	79	79
	95th	121	122	123	124	126	127	128	80	80	80	81	82	83	83
	99th	128	129	130	132	133	134	135	87	87	88	89	89	90	91
14	50th	106	106	107	109	110	111	112	63	63	63	64	65	66	66
	90th	119	120	121	122	124	125	125	77	77	77	78	79	80	80
	95th	123	123	125	126	127	129	129	81	81	81	82	83	84	84
	99th	130	131	132	133	135	136	136	88	88	89	90	90	91	92
15	50th	107	108	109	110	111	113	113	64	64	64	65	66	67	67
	90th	120	121	122	123	125	126	127	78	78	78	79	80	81	81
	95th	124	125	126	127	129	130	131	82	82	82	83	84	85	85
	99th	131	132	133	134	136	137	138	89	89	90	91	91	92	93
16	50th	108	108	110	111	112	114	114	64	64	65	66	66	67	68
	90th	121	122	123	124	126	127	128	78	78	79	80	81	81	82
	95th	125	126	127	128	130	131	132	82	82	83	84	85	85	86
	99th	132	133	134	135	137	138	139	90	90	90	91	92	93	93
17	50th	108	109	110	111	113	114	115	64	65	65	66	67	67	68
	90th	122	122	123	125	126	127	128	78	79	79	80	81	81	82
	95th	125	126	127	129	130	131	132	82	83	83	84	85	85	86
	99th	133	133	134	136	137	138	139	90	90	91	91	92	93	93

1. Use the standard height chart to determine the height percentile.
2. Measure and record the adolescent's systolic blood pressure and diastolic blood pressure levels.
3. Find the adolescent's age on the left side of the table. Follow the age row horizontally across the table to the intersection of the line for the height percentile (vertical column).
4. Find the 50th, 90th, 95th, and 99th percentiles for systolic blood pressure levels in the left columns and for diastolic blood pressure levels in the right columns.
 - A blood pressure level less than the 90th percentile is normal.
 - A blood pressure level between the 90th and 95th percentile is prehypertension and an indication for lifestyle modifications. In adolescents, a blood pressure level greater than or equal to 120/80 mm Hg is prehypertension, even if this figure is less than the 90th percentile.
 - A blood pressure level greater than the 95th percentile may be hypertension.
5. If the blood pressure level is greater than the 90th percentile, it should be measured twice during the same office visit, and average systolic blood pressure and diastolic blood pressure levels should be used.
6. If the blood pressure level is greater than the 95th percentile, it should be staged. If it is found to be stage 1 (95th percentile to the 99th percentile plus 5 mm Hg), measurements should be repeated on two more occasions. If hypertension is confirmed, an evaluation should follow. If the blood pressure level is found to be stage 2 (greater than the 99th percentile plus 5 mm Hg), prompt referral should be made for evaluation and therapy. If the patient is symptomatic, immediate referral and treatment are indicated.

Fig. 1. Blood pressure levels for adolescent girls by age and height percentile. For those 18 years of age and older, hypertension is defined as a systolic blood pressure level of 140 mm Hg or higher or a diastolic blood pressure level of 90 mm Hg or higher. Normal blood pressure level is a systolic blood pressure of less than 120 mm Hg and a diastolic blood pressure level of less than 80 mm Hg. Prehypertension is defined as a systolic blood pressure level of 120–139 mm Hg or a diastolic blood pressure level of 80–89 mm Hg. Individuals with prehypertension are at increased risk of progressing to hypertension. (The fourth report on the diagnosis, evaluation, and treatment of high blood pressure in children and adolescents. National High Blood Pressure Education Program Working Group on High Blood Pressure in Children and Adolescents. *Pediatrics* 2004;114(suppl):555. Available at: <http://pediatrics.aappublications.org/cgi/reprint/114/2/S2/555.pdf>. Retrieved November 5, 2007.)

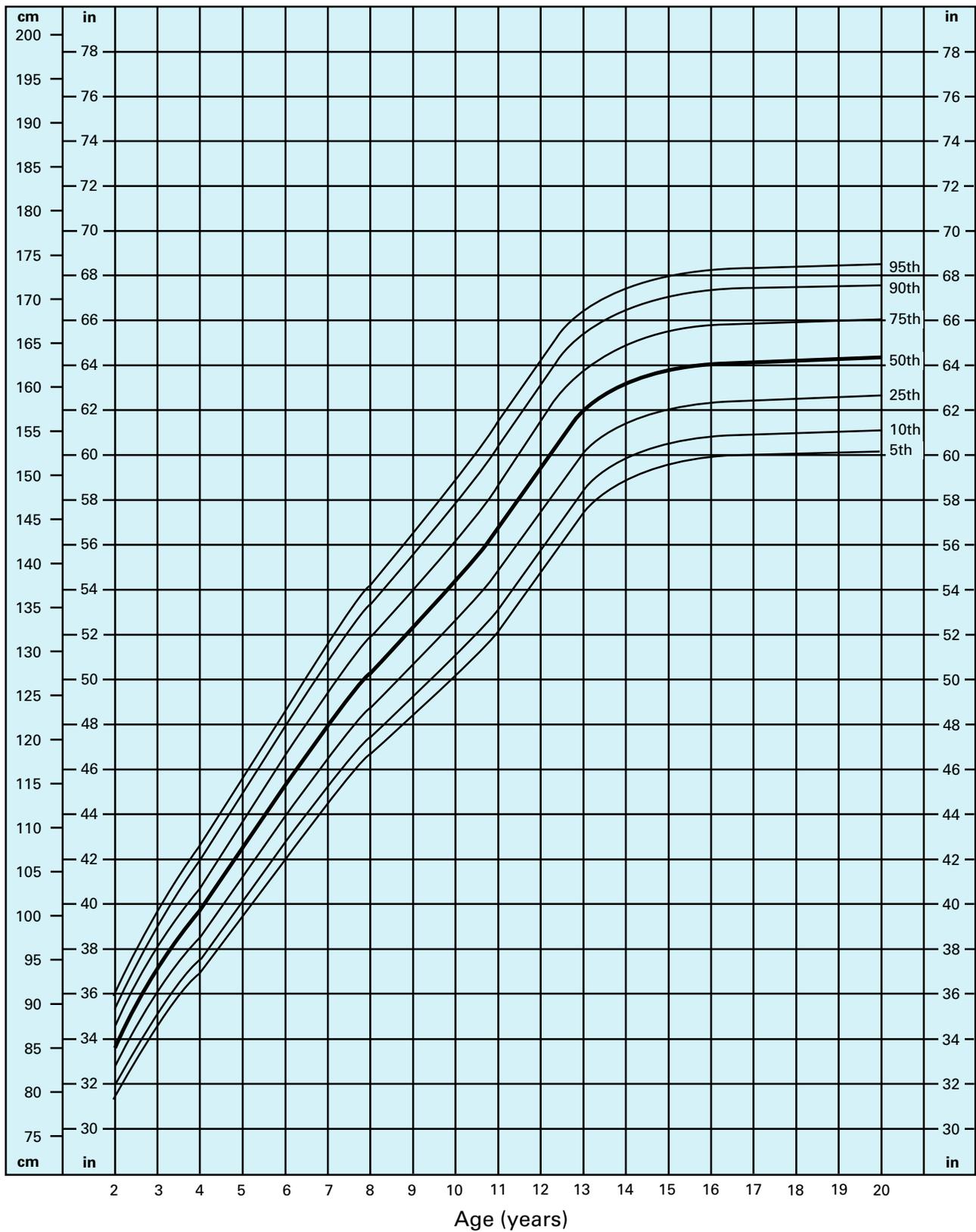


Fig. 2. Height-for-age percentiles: girls aged 2–20 years in the United States. (Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion [2000].)

- Adolescents who have a parent or grandparent with coronary artery disease, peripheral vascular disease, cerebrovascular disease, or sudden cardiac death at age 55 years or younger should be screened with a fasting lipoprotein profile.
- Treatment options are based on the average of two assessments of low-density lipoprotein cholesterol. Values less than 110 mg/dL are acceptable; values between 110 mg/dL and 120 mg/dL are borderline, and the lipoprotein status should be reevaluated in 1 year. Adolescents with values of 130 mg/dL or greater will need further evaluation.

Weight Issues

All adolescents should be screened annually for eating disorders and obesity by determining weight and stature, calculating a body mass index (BMI) (Fig. 3 and Fig. 4), and asking about body image and eating patterns (11).

Tobacco

All adolescents should be asked annually about their use of tobacco products (7). Approximately 22% of high-school seniors have smoked within the past month, and females are as likely as males to be smokers. Screening for tobacco use should include the following components:

- Adolescents who smoke or use any tobacco products should be assessed further to determine their pattern of use.
- Because of an adolescent's preoccupation with body image, all adolescents should be counseled on the effects of smoking and other tobacco products on their hair, skin, fingernails, teeth, and breath, as well as on athletic performance.
- Counseling also should include long-term health consequences.
- A cessation plan should be available for adolescents who smoke or use any tobacco products. Appropriate nicotine therapy should be considered when there is strong evidence of nicotine dependence and a clear desire to quit using tobacco (12).

Alcohol and Other Drugs

All adolescents should be asked annually about their use of alcohol and other drugs, including street drugs, over-the-counter and prescription drugs for nonmedical purposes, and inhalants (7). Substance abuse occurs frequently in adolescence, is a major factor in injuries and deaths among adolescents, and contributes to motor vehicle crashes, homicide, and suicide.

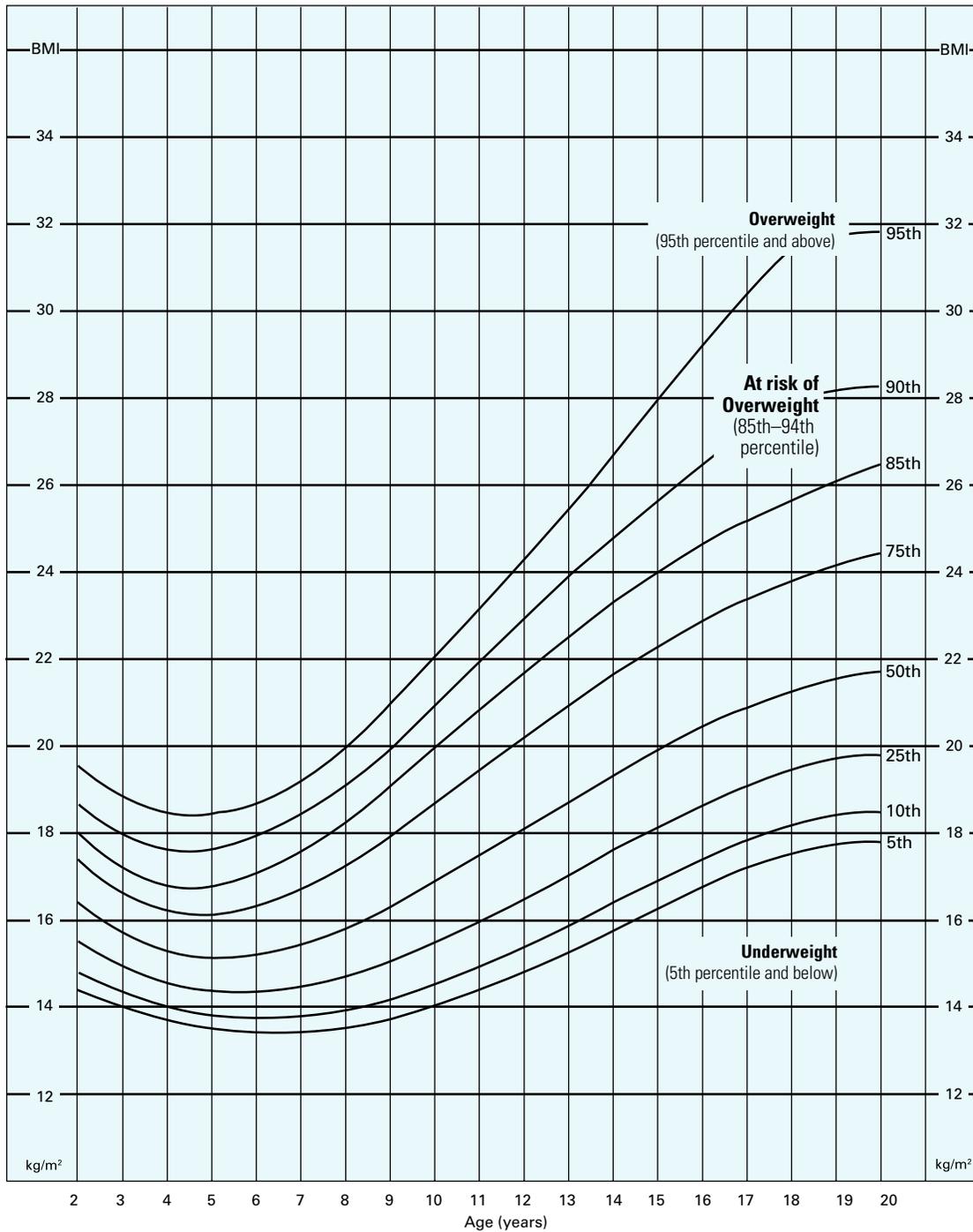


Fig. 4. Body mass index by age: girls. (Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion [2000].)

C Have you ever ridden in a **CAR** driven by someone (including yourself) who was high or had been using alcohol or drugs?

R Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?

A Do you ever use alcohol or drugs while you are by yourself **ALONE**?

F Do you ever **FORGET** things you did while using alcohol or drugs?

F Do your **FAMILY** or friends ever tell you that you should cut down on your drinking or drug use?

T Have you ever gotten in **TROUBLE** while you were using alcohol or drugs?

Scoring: two or more positive items indicate the need for further assessment.

Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Arch Pediatr Adolesc Med* 2002;156:607–14. Copyright © 2002, American Medical Association. All Rights reserved.

Screening for alcohol and drug use should include the following components:

- A standardized, evidence-based screening method should be used. A short, validated tool for screening adolescents is the CRAFFT substance abuse screening test, which can be incorporated into a previsit questionnaire (see box).
- Adolescents who report any use of alcohol or other drugs or inappropriate use of medications during the past year should be assessed further regarding family history, circumstances surrounding use, amount and frequency of use, attitudes and motivation to use, use of other drugs, and the adequacy of physical, psychosocial, and school functioning.
- Adolescents whose substance use endangers their health or safety should receive counseling and treatment, and be assessed for co-occurring depression, anxiety, and other mental disorders.
- Urine screening for drug use in adolescents without the adolescent's prior informed consent is not recommended.

Sexual Activity

All adolescents should be asked annually about their involvement in sexual behaviors that may result in unintended pregnancy and STDs, including HIV infection. High rates of sexual activity, coupled with inconsistent use of contraception, contribute to the United States having one of the highest adolescent pregnancy rates in the developed world. Currently, 8 out of every 100 female teenagers continue to become pregnant annually (13).

Adolescents should be counseled that abstinence is the only choice that assures protection from STDs and pregnancy. Clinicians should not limit their patient interview to questions about heterosexual vaginal–penile intercourse (14). Oral–genital contact is a common behavior among adolescents and, along with anal–genital contact, contributes to the transmission of STDs. One study indicated that 9% of high-school virgins engaged in heterosexual fellatio with ejaculation, 10% engaged in heterosexual cunnilingus, and 1% engaged in heterosexual anal intercourse. Condom use for fellatio was rare (15). Vulva-to-vulva sex also can transmit STDs. Generally, STDs, including HIV, are less common in lesbians than in heterosexual women, but they can be passed from woman to woman. Also, many women who identify themselves as lesbians may be having or may have had sexual intercourse with men.

Sexually active patients must be educated about the safety and efficacy of current contraceptive options. The most effective protection against unintended pregnancy and STDs, other than abstinence, includes a combination of latex condoms and intrauterine devices or hormonal methods of contraception. Adolescents also should be counseled about emergency contraceptive methods. If they are 17 years and older, they should be informed that emer-

gency contraception is available over the counter. If they are younger than 17 years, they should be provided with an advance prescription. Although emergency contraception pills can prevent unintended pregnancies after episodes of unprotected sexual intercourse or method failure, they afford no protection against STDs. Clinicians also should ascertain if their adolescent patients are in new relationships or have multiple concurrent partners, which are important predictors of incident STDs (16).

Pregnant adolescents whose pregnancies are unintended (either mistimed or unwanted) should be counseled about pregnancy options, including adoption, raising the baby, and termination. The practitioner must be knowledgeable about local support services and state laws regarding parental notification and consent for elective termination of pregnancy. If the adolescent continues with the pregnancy, the importance of prenatal care should be emphasized and appropriate follow-up care should be arranged. For pregnant school-aged adolescents, the importance of completing high school should be stressed.

Screening for sexual activity should include the following points:

- Sexually active adolescents should be asked about their sexual orientation, partner use of condoms, contraceptive methods, number of current and previous sexual partners, exchange of sex for money or drugs, and history of prior pregnancy or STDs.
- Before asking these questions, practitioners should clearly disclose to the patient the state laws regarding reporting requirements. Practitioners should be aware of their states' laws regarding the age of sexual consent and age of partners. The practitioner should be aware that certain information disclosed may require legal reporting. Although a wide discrepancy in age between partners is of concern when caring for the adolescent patient, partner age by itself is not indicative of exploitation or abuse. Sexual abuse and exploitation of an adolescent may occur in any relationship, including those in which the partners are the same age, younger, or older (17). Based on the patient's response, a careful assessment is needed to determine the likelihood of abuse.
- Adolescents at risk for pregnancy, STDs (including HIV), or sexual exploitation should be counseled on strategies to reduce their risk.

Sexually Transmitted Diseases

Sexually transmitted diseases are the most common infectious diseases among adolescents and, as a group, they are at the greatest risk. Recent estimates suggest that, although representing 25% of the sexually active population, individuals aged 15–24 years acquire nearly half of the 19 million new STDs in the United States annually (18). As such, sexually active adolescents should be screened annually for STDs, including the following diseases:

- Gonorrhea, chlamydia, and HIV (19, 20)
- Syphilis, for the following situations (21):
 - Had multiple sexual partners

- Exchanged sex for drugs or money
- Used intravenous drugs
- Been admitted to jail or other detention facility
- Lived in an endemic area

Bacterial vaginosis and trichomoniasis are both highly prevalent in the adolescent population and can be associated with development of pelvic inflammatory disease. In addition, many teens have a substantial amount of discharge and do not recognize or report it as a problem. Testing of all symptomatic teens is important for diagnosis and treatment.

Depression and Suicide Risk

All adolescents should be asked annually about emotions and behaviors that indicate recurrent or severe depression and thoughts of killing or harming themselves. Feelings of sadness should not be dismissed as mere moodiness in this patient population. Situational losses, relationship and school problems, parental loss, and parental conflicts may lead to depression as well as to suicidal ideation. Recognition of depression and subsequent intervention can reduce suicidal behaviors in adolescent women (22).

Abuse

According to the Commonwealth Fund's Commission on Women's Health, 26% of adolescent girls in grades 9–12 report experiencing physical or sexual abuse or sexual assault, including acquaintance rape (8). Given this high incidence, all adolescents should be asked annually about a history of experiencing or witnessing abuse, including emotional, physical, and sexual abuse and assault by family members, peers, romantic partners, and others. (For more information please see the section "Sexual Assault" in the ACOG book *Special Issues in Women's Health*.) Screening recommendations are listed as follows:

- If abuse or assault is suspected, adolescents should be questioned regarding the circumstances surrounding the abuse; assessed for physical, emotional, and psychosocial consequences, such as posttraumatic stress disorder; and screened for involvement in risky health behaviors.
- In patients with posttraumatic stress disorder, the clinician should be aware that various health care procedures can be triggers for panic and anxiety reactions.
- Health providers should be aware of state and local laws requiring breach of confidentiality and reporting of abuse and assault to mandated officials.
- Adolescents who report or demonstrate emotional or psychosocial sequelae from abuse or assault should be referred to a knowledgeable mental health professional for evaluation and treatment.

School Performance and Attendance

Education is one of the strongest predictors of health. That is, the more schooling an individual has the better their health is likely to be (23). Adolescents should be asked their grades in each class during the current and previous years. A decrease in performance should be assessed annually for learning or school-related problems. Adolescents with a history of truancy, repeated absences, or poor or decreased performance should be assessed or referred to other professionals to screen for the presence of conditions that could interfere with school success. These include learning disabilities, attention deficit hyperactivity disorder, medical problems, abuse, family dysfunction, mental disorder, and alcohol or other drug use. This assessment and the subsequent management should be coordinated with school personnel, the primary medical care provider (if different from the obstetrician–gynecologist), and the adolescent’s parents.



Tuberculosis

Adolescents should be evaluated for their tuberculosis risk status. Adolescents should receive a tuberculin skin test in the following instances (24):

- They have been exposed to active tuberculosis
- They have lived in a homeless shelter, been incarcerated, or lived in another long-term care facility
- They have lived in or come from an area with a high prevalence of tuberculosis, or lived with individuals known or suspected to have tuberculosis
- They are currently working in a health care setting
- They are HIV positive
- They are medically underserved or of low-income status
- They have a history of alcoholism
- They have medical risk factors known to increase the likelihood of developing other conditions or complications associated with tuberculosis

The frequency of testing depends on the individual adolescent’s risk factors. Adolescents with positive tuberculin test results should be treated according to the treatment guidelines put forth jointly by the Centers for Disease Control and Prevention (CDC) and the American Thoracic Society (24).

IMMUNIZATION

All adolescents should receive prophylactic immunizations according to the most recent guidelines established by the federally convened Advisory Committee on Immunization Practices (25) (Fig. 5). Physicians should determine the numbers and types of previous vaccinations and school requirements to assess the immunization needs of adolescents. It also is important to be aware of reimbursement by local insurance companies, the federal Vaccines for Children Program, as well as various state programs.

Ideally, all vaccinations should be administered at the scheduled 11–12-year visit. However, in many instances it will be necessary for physicians to administer vaccines to those who have fallen behind the recommended schedule or who were older than 11–12 years when the recommendations were formulated. Before administering immunizations, physicians should ensure that, if required, the necessary parental consent has been obtained.

It is important for obstetrician–gynecologists and other health care providers to keep updated on the latest recommendations for immunizations. These recommendations can be found online (www.cdc.gov/vaccines/). The Centers for Disease Control and Prevention Advisory Committee on Immunization Practices recently recommended that the ages for annual influenza vaccination be expanded to include all children and adolescents from the ages of 6 months through 18 years. The previous recommendation was for vaccination of children from the ages of 6–59 months of age. The Advisory Committee on Immunization Practices also continues to recommend vaccination of all children and adolescents who are at greater risk from the complications of influenza, such as those who have certain chronic medical conditions, such as asthma, diabetes mellitus, kidney disease or weakened immune systems or who will become pregnant during the influenza season. Results from research have indicated that healthy children bear a significant burden from influenza disease and are more likely to need influenza-related medical care. In addition, there is evidence showing that reducing influenza transmission among children has the potential of reducing influenza among household and community contacts.

CONCLUSION

Although most adolescents enjoy good health, many of their behaviors put them at risk for negative health outcomes. Consequently, a fundamental change in the provision of health care services is required. Increasingly, services must be directed at primary and secondary prevention. As such, obstetrician–gynecologists should respond by making preventive services a greater component of their clinical practice. The approach outlined previously can help in this transition and can ensure that adolescents receive the services their health status demands. To be successful in this capacity, a collaborative relationship with others providing health care to adolescents is critical.

Age	7–10 Years	11–12 Years	13–18 Years
Vaccine			
Tetanus, Diphtheria, Pertussis ¹		Tdap	Tdap
Human papillomavirus ²	see footnote 2	HPV (three doses)	HPV Series
Meningococcal ³	MCV	MCV	MCV
Influenza ⁴		Influenza (Yearly)	
Pneumococcal ⁵		PPSV	
Hepatitis A ⁶		HepA Series	
Hepatitis B ⁷		HepB Series	
Inactivated Poliovirus ⁸		IPV Series	
Measles, Mumps, Rubella ⁹		MMR Series	
Varicella ¹⁰		Varicella Series	

- Range of recommended ages for all children except certain high-risk groups
- Range of recommended ages for catch-up immunization
- Range of recommended ages for certain high-risk groups

This schedule includes recommendations in effect as of December 15, 2009. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations: <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967.

1. **Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap)** (Minimum age: 10 years for Boostrix and 11 years for Adacel)
 - Administer at age 11 or 12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a tetanus and diphtheria toxoid (Td) booster dose.
 - Persons aged 13 through 18 years who have not received Tdap should receive a dose.
 - A 5-year interval from the last Td dose is encouraged when Tdap is used as a booster dose; however, a shorter interval may be used if pertussis immunity is needed.
2. **Human papillomavirus vaccine (HPV)** (Minimum age: 9 years)
 - Two HPV vaccines are licensed: a quadrivalent vaccine (HPV4) for the prevention of cervical, vaginal and vulvar cancers (in females) and genital warts (in females and males), and a bivalent vaccine (HPV2) for the prevention of cervical cancers in females.
 - HPV vaccines are most effective for both males and females when given before exposure to HPV through sexual contact.
 - HPV4 or HPV2 is recommended for the prevention of cervical precancers and cancers in females.
 - HPV4 is recommended for the prevention of cervical, vaginal and vulvar precancers and cancers and genital warts in females.
 - Administer the first dose to females at age 11 or 12 years.
 - Administer the second dose 1 to 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).
 - Administer the series to females at age 13 through 18 years if not previously vaccinated.
 - HPV4 may be administered in a 3-dose series to males aged 9 through 18 years to reduce their likelihood of acquiring genital warts.
3. **Meningococcal conjugate vaccine (MCV4)**
 - Administer at age 11 or 12 years, or at age 13 through 18 years if not previously vaccinated.
 - Administer to previously unvaccinated college freshmen living in a dormitory.
 - Administer MCV4 to children aged 2 through 10 years with persistent complement component deficiency, anatomic or functional asplenia, or certain other conditions placing them at high risk.
 - Administer to children previously vaccinated with MCV4 or MPSV4 who remain at increased risk after 3 years (if first dose administered at age 2 through 6 years) or after 5 years (if first dose administered at age 7 years or older). Persons whose only risk factor is living in on-campus housing are not recommended to receive an additional dose. See MMWR 2009;58:1042–3.

4. **Influenza vaccine (seasonal)**
 - Administer annually to children aged 6 months through 18 years.
 - For healthy nonpregnant persons aged 7 through 18 years (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used.
 - Administer 2 doses (separated by at least 4 weeks) to children aged younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.
 - For recommendations for use of influenza A (H1N1) 2009 monovalent vaccine. See MMWR 2009;58(No. RR-10).
5. **Pneumococcal polysaccharide vaccine (PPSV)**
 - Administer to children with certain underlying medical conditions, including a cochlear implant. A single revaccination should be administered after 5 years to children with functional or anatomic asplenia or an immunocompromising condition. See MMWR 1997;46(No. RR-8).
6. **Hepatitis A vaccine (HepA)**
 - Administer 2 doses at least 6 months apart.
 - HepA is recommended for children aged older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A is desired.
7. **Hepatitis B vaccine (HepB)**
 - Administer the 3-dose series to those not previously vaccinated.
 - A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB is licensed for children aged 11 through 15 years.
8. **Inactivated poliovirus vaccine (IPV)**
 - The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
 - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.
9. **Measles, mumps, and rubella vaccine (MMR)**
 - If not previously vaccinated, administer 2 doses or the second dose for those who have received only 1 dose, with at least 28 days between doses.
10. **Varicella vaccine**
 - For persons aged 7 through 18 years without evidence of immunity (see MMWR 2007;56[No. RR-4]), administer 2 doses if not previously vaccinated or the second dose if only 1 dose has been administered.
 - For persons aged 7 through 12 years, the minimum interval between doses is 3 months. However, if the second dose was administered at least 28 days after the first dose, it can be accepted as valid.
 - For persons aged 13 years and older, the minimum interval between doses is 28 days.

The Recommended Immunization Schedules for Persons Aged 0 through 18 Years are approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/vaccines/recs/acip>), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).

Fig. 5. Recommended immunization schedule for persons aged 7 through 18 years—United States, 2010. For those who fall behind or start late, see the white bars and the catch-up schedule. (Centers for Disease Control and Prevention. Recommended immunization schedule for persons aged 7–18 years—United States 2010. Atlanta (GA): CDC; 2010. Available at: http://www.cdc.gov/vaccines/recs/schedules/downloads/child/2010/10_7-18yrs_schedule_pr.pdf. Retrieved April 13, 2010.)

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RESOURCES

ACOG Resources

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Other Resources

American Academy of Family Physicians
Telephone: (913) 906-6000 or (800) 274-2237
Web: www.aafp.org

American Academy of Pediatrics
Telephone: (847) 434-4000
Web: www.aap.org

American Medical Association
Telephone: (800) 621-8335
Web: www.ama-assn.org

Centers for Disease Control and Prevention
Telephone: (404) 639-3534 or (800) 311-3435
Web: www.cdc.gov

Society for Adolescent Health and Medicine
Telephone: (847) 753-5226
Web: www.adolescenthealth.org

Society of Obstetricians and Gynaecologists of Canada
Telephone: (613) 730-4192 or (800) 561-2416
Web: http://sogc.medical.org/index_e.asp
www.sexualityandu.ca/home_e.aspx

Resources for Your Patients

Center for Young Women's Health
Telephone: (617) 355-2994
Web: www.youngwomenshealth.org

Go Ask Alice!
Telephone: (212) 854-5453
Web: www.goaskalice.columbia.edu

National Women's Health Information Center
Office on Women's Health
Department of Health and Human Services
Telephone: (800) 994-9662
Web: www.4.woman.gov

Teenwire
Planned Parenthood Federation of America
Tel: (212) 541-7800 or (800) 230-PLAN (7526)
Web: www.teenwire.com