The Initial Reproductive Health Visit

**ABSTRACT:** The primary goal of the initial reproductive health visit is to provide preventive health care services, educational information, and guidance, in addition to problem-focused care. The initial reproductive health visit should take place between the ages of 13 and 15 years. The scope of the initial visit will depend on the patient’s concerns, medical history, physical and emotional development, and the level of care the patient is receiving from other health care professionals. All adolescents should have the opportunity to discuss health issues with a health care professional one-on-one, because they may feel uncomfortable talking about these issues in the presence of a parent or guardian, sibling, or intimate partner. Addressing confidentiality concerns is imperative because adolescents in need of health care services are more likely to forego care if there are concerns about confidentiality. Laws regarding confidentiality of care to minors vary by state, and health care professionals should be knowledgeable about current laws for their practice. Taking care to establish secure lines of communication can build trust with the patient and guardian, support continuity of care, ensure adherence to legal statutes, and decrease barriers to services. Obstetrician–gynecologists have the opportunity to serve as educators of parents and guardians about reproductive health issues. Preparing the office environment to include adolescent-friendly and age-appropriate reading materials, intake forms, and educational visual aids can make the general office space more inclusive and accessible. Resources should be provided for both the adolescent patient and the parent or guardian, if possible, at the conclusion of the visit. This Committee Opinion has been updated to include gender neutral terminology throughout the document, counseling topics with direct links to helpful resources, screening tools with direct links, addition of gender and sexuality discussion, and inclusion of trauma-informed care.

**Recommendations and Conclusions**

The American College of Obstetricians and Gynecologists makes the following recommendations and conclusions:

- The initial reproductive health visit should take place between the ages of 13 and 15 years.
- Creating an adolescent-friendly environment is important to make the patient feel comfortable and to establish a good relationship for continued care.
- Office staff should be trained to be sensitive to the needs of the adolescent regarding contact and communication, interaction with parents or guardians, and front office procedures.
- Training should include increasing comfort with issues regarding adolescent sexuality, respectfully addressing gender and sexual diversity, and being aware of other potential barriers, such as language access (access to language interpretation and also age-appropriate and youth culture-appropriate language), negotiating parent or guardian participation in the visit, and confidentiality.
- At the initial visit, adolescents should be made aware of the limitations of confidentiality including issues related to state-specific mandatory reporting and insurance billing, notifications to parents and guardians through electronic health records (EHRs) and patient portals, and legal requirements of
During the initial consultation with the patient and parent or guardian, the obstetrician–gynecologist should inform them that the visit usually does not require an internal pelvic examination, unless indicated by symptoms, and that cervical cancer screening begins at postadolescence.

All adolescents should have the opportunity to discuss health issues with a health care professional one-on-one, because they may feel uncomfortable talking about these issues in the presence of a parent or guardian, sibling, or intimate partner.

Before completing an examination, the obstetrician–gynecologist should counsel the patient about what to expect for the physical examination portion of the visit, identify if there are patient concerns, and ask about the patient’s level of comfort. In some cases, a physical examination might be performed at a separate visit.

At the completion of the physical examination, the health care professional should address physical findings, diagnosis, and potential treatment options. Once a treatment plan has been mutually decided upon, the adolescent is encouraged to include the parent or guardian in the management plan.

This Committee Opinion has been updated to include gender neutral terminology throughout the document, counseling topics with direct links to helpful resources, screening tools with direct links, addition of gender and sexuality discussion, and inclusion of trauma-informed care. If a gynecologist is uncomfortable providing reproductive health care and contraception to adolescents, the professional should refer the patient to a different reproductive health care professional who is comfortable working with these patients. Obstetrician–gynecologists have the duty to refer patients in a timely manner to other health care professionals if they do not feel that they can provide the standard reproductive services that their patients request (1).

## Creating an Inclusive and Adolescent-Friendly Environment

Creating an adolescent-friendly environment is important to make the patient feel comfortable and to establish a good relationship for continued care (Box 1). Preparing the office environment to include adolescent-friendly and age-appropriate reading materials, intake forms, and educational visual aids can make the general office space more inclusive and accessible. Providing a confidential questionnaire for the patient to complete about sexual history, social history (eg, drug or alcohol use, or both), and contraceptive needs can help to identify psychosocial needs; ideally, this can be done when patients are separate from their parents or guardian. However, some patients may not be comfortable sharing personal information in writing before meeting with a gynecologic care professional. A written questionnaire is one source of potential communication; some adolescents may prefer verbal communication directly with the health care professional. Further designating and designating specific rooms to be adolescent-friendly can allow the patient to explore reading material and brochures confidentially, out of view from other patients, parents, or guardians. The obstetrician–gynecologist should provide education with the use of models and visual diagrams to engage the patient.

### Training for Office Staff

Office staff should be trained to be sensitive to the needs of the adolescent regarding contact and communication, interaction with parents or guardians, and front office procedures. Training should include increasing comfort with issues regarding adolescent sexuality, respectfully addressing gender and sexual diversity, and being aware of other potential barriers, such as language access (access to language interpretation and also age-appropriate and youth culture-appropriate language), negotiating parent or guardian participation in the visit, and confidentiality. Although initial reproductive health visits have the potential to be uncomfortable for all adolescents, they may be even more so for transgender and nonbinary patients because of assumptions about gender associated with the visit, lack of health care professional and staff knowledge, and fear of discrimination (2). See Box 2 for issues to be addressed in staff training.

### Box 1. Tips for Creating an Office Environment That Appeals to Adolescents

1. Nonpregnant adolescents might be intimidated by a reception area full of obstetric patients; therefore, consider seeing adolescent gynecology patients during a dedicated time.
2. Many adolescents and parents prefer after-school appointments.
3. Make sure your reception area and examination rooms contain age-appropriate and culturally inclusive reading materials and audiovisual aids.
4. Consider having one or two rooms where adolescents are seen and examined. Remove or de-emphasize materials and equipment (eg, colposcope) that make adolescents uncomfortable during their visit.
5. Designate a place for the parent(s) or guardian(s) to wait that is away from the examination room. Be certain that the adolescent patient understands that the parent(s) or guardian(s) is (are) not within hearing range (eg, avoid letting them wait in the hall outside the examination room).
Confidentiality and Patient Autonomy

Addressing confidentiality concerns is imperative because adolescents in need of health care services are more likely to forego care if there are concerns about confidentiality (3). Laws regarding confidentiality of care to minors vary by state, and health care professionals should be knowledgeable about current laws for their practice (4). At the initial visit, adolescents should be made aware of the limitations of confidentiality, including issues related to state-specific mandatory reporting and insurance billing, notifications to parents and guardians through EHRs and patient portals, and legal requirements of parental notification related to specific services (eg, abortion) (4). Traditionally, minors may provide informed assent rather than consent for medical therapies. In contrast to informed consent, informed assent entails involving young patients in discussions and decisions about their care as appropriate for their developmental stage. This approach respects the developing independence and autonomy of minors by allowing them to be involved in their medical decision making, while acknowledging the need to obtain authorization to treat from their parents or guardians (5). See ACOG Committee Opinion No. 803, Confidentiality in Adolescent Health Care, for more details on confidentiality in the provision of health care for adolescents (4).

Obstetrician–gynecologists and other health care professionals should develop a system for discussing the importance of confidential services with the patient and guardians, communication protocols for verifying patient release of information, and safeguards for EHR or insurance billing information breaches. Taking care to establish secure lines of communication can build trust with the patient and guardian, support continuity of care, ensure adherence to legal statutes, and decrease barriers to services.

Alone Time

All adolescents should have the opportunity to discuss health issues with a health care professional one-on-one, because they may feel uncomfortable talking about these issues in the presence of a parent or guardian, sibling, or intimate partner (4). Recognizing that some of these issues are sensitive in nature, it may be appropriate for a non-parental support person to be in the room (eg, a friend), if a patient prefers. During time alone with the patient, the obstetrician–gynecologist can discuss issues such as those included in Table 1. If a parent or guardian desires time alone with the obstetrician–gynecologist, this should be discussed with the adolescent patient and should occur before the obstetrician–gynecologist spends time alone with the patient, if possible, to reassure the adolescent patient that confidentiality will be maintained.

Gender Identity and Sexuality

The initial visit is a prime opportunity for the obstetrician–gynecologist to build trust with the patient. Discussion of gender and sexuality should be explored with open, nonjudgmental, and nonassuming questions. Asking all patients routinely for their gender identity and gender pronouns normalizes the interaction and allows patients to disclose without being targeted; good practice includes reciprocal disclosure (eg, “Hello, I am Dr. Singh and I use she/her pronouns. Is the name on your chart what you would like me to call you? What pronouns do you use?”). Obstetrician–gynecologists also can counsel patients about contraception for gender-affirming menstrual control or inquire about the adolescent’s other gender affirmation concerns, such as mental health, bullying, family support, or desire for hormone therapy.

Taking a Sexual History

Sexual history questions (Box 3) can help guide the discussion on sexuality, sexual orientation, and sexual behavior. The obstetrician–gynecologist should discuss contraception and STIs associated with coital and noncoital sexual activity (6). Discussing previous sexual activity and asking patient about plans for sexual activity can provide an opportunity to share anticipatory guidance for the prevention of pregnancy, if desired, and STIs. It may be an appropriate and useful time to provide education about gynecologic anatomy, including the
<table>
<thead>
<tr>
<th>Counseling Topics</th>
<th>Resources</th>
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• Guttmacher Institute, An Overview of Consent to Reproductive Health Services by Young People [https://www.guttmacher.org/state-policy/explore/overview-minors-consent-law](https://www.guttmacher.org/state-policy/explore/overview-minors-consent-law)  
| Anatomy | • Typical anatomy  
• Great Wall of Vagina [http://www.greatwallofvagina.co.uk/home](http://www.greatwallofvagina.co.uk/home) |
| Pubertal development | • ACOG Patient Education: You and Your Sexuality (Especially for Teens) [FAQ042] [https://www.acog.org/patient-resources/faqs/especially-for-teens/you-and-your-sexuality](https://www.acog.org/patient-resources/faqs/especially-for-teens/you-and-your-sexuality)  
• ACOG Patient Education: Media and Body Image [FAQ002] [https://www.acog.org/patient-resources/faqs/especially-for-teens/media-and-body-image](https://www.acog.org/patient-resources/faqs/especially-for-teens/media-and-body-image) |
| Menstruation | • Normal menses  
• Menstrual hygiene  
• Menstrual products  
• Electronic applications  
• ACOG Patient Education: Your First Period (Especially for Teens) [FAQ049] [https://www.acog.org/patient-resources/faqs/especially-for-teens/your-first-period](https://www.acog.org/patient-resources/faqs/especially-for-teens/your-first-period)  
| Immunizations | • ACOG Immunization webpage, including ACOG’s HPV Vaccination Toolkit [https://www.acog.org/topics/immunization](https://www.acog.org/topics/immunization)  
| Nicotine | • Vaping  
• American Academy of Pediatrics: Policy Statement: E-Cigarettes and Similar Devices [https://pediatrics.aappublications.org/content/143/2/e20183652](https://pediatrics.aappublications.org/content/143/2/e20183652) |

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<th>Counseling Topics</th>
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  • World Professional Association for Transgender Health (WPATH): Standards of Care for Gender Identity Disorders  
  https://www.wpath.org/publications/soc  
  • Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline  
  • Lesbian, Gay, Bisexual, and Transgender Community Center: Trans Basics  
  https://gaycenter.org/recovery-health/health/tgnc/#transgender-basics  
  • National LGBT Health Education Center  
  https://www.lgbthealtheducation.org/ |
| Healthy relationships and consent        | • ACOG Committee Opinion No. 758 *Promoting Healthy Relationships in Adolescents* https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/11/promoting-healthy-relationships-in-adolescents  
  • ACOG Committee Opinion No. 777 *Sexual Assault* https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/04/sexual-assault  
  • ACOG Committee Opinion No. 518 *Intimate Partner Violence* https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2012/02/intimate-partner-violence  
  • ACOG Committee Opinion No. 653 *Concerns Regarding Social Media and Health Issues in Adolescents and Young Adults* https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2016/02/concerns-regarding-social-media-and-health-issues-in-adolescents-and-young-adults  
| Physical activity                        | • ACOG Committee Opinion No. 714 *Obesity in Adolescents* https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/09/obesity-in-adolescents  
  • ACOG Committee Opinion No. 423 *Motivational Interviewing: A Tool for Behavior Change* https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2009/01/motivational-interviewing-a-tool-for-behavior-change |
| Tanning and skin health                  | • Tanning and Tanning Salon Safety Tips for Young People from the American Academy of Pediatrics https://healthychildren.org/English/ages-stages/teen/Pages/Teens-Tanning-Safety-Information-for-Parents.aspx  
  • American Academy of Pediatrics’ Statement on FDA’s Action to Prohibit Tanning Bed Use by Children under 18  
| Mental health                            | • ACOG Committee Opinion No. 705 *Mental Health Disorders in Adolescents* https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/07/mental-health-disorders-in-adolescents  
  The Patient Health Questionnaire (PHQ) Screeners https://www.phqscreeners.com |
Table 1. Counseling Topics That May Be Addressed During an Initial Visit* (continued)

<table>
<thead>
<tr>
<th>Counseling Topics</th>
<th>Resources</th>
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<tbody>
<tr>
<td>Sexuality</td>
<td>• ACOG Committee Opinion No. 678 Comprehensive Sexuality Education</td>
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<td>Contraception and pregnancy prevention</td>
<td>• ACOG Committee Opinion No. 710 Counseling Adolescents About Contraception</td>
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<td><a href="https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/counseling-adolescents-about-contraception">https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/counseling-adolescents-about-contraception</a></td>
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<td>• ACOG Committee Opinion No. 699 Adolescent Pregnancy, Contraception, and Sexual Activity</td>
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<td><a href="https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/05/adolescent-pregnancy-contraception-and-sexual-activity">https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/05/adolescent-pregnancy-contraception-and-sexual-activity</a></td>
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<td>• ACOG Committee Opinion No. 735 Adolescents and Long-Acting Reversible Contraception: Implants and Intrauterine Devices</td>
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<td></td>
<td>• ACOG Practice Bulletin No. 186, Long-Acting Reversible Contraception: Implants and Intrauterine Devices</td>
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<td>• ACOG Practice Bulletin No. 152, Emergency Contraception</td>
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<td></td>
<td>• ACOG Patient Education: Birth Control (Especially for Teens) (FAQ112)</td>
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<td><a href="https://www.acog.org/patient-resources/faqs/especially-for-teams/birth-control">https://www.acog.org/patient-resources/faqs/especially-for-teams/birth-control</a></td>
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<td>• ACOG Patient Education: Barrier Methods of Birth Control: Spermicide, Condom, Sponge, Diaphragm, and Cervical Cap (FAQ022)</td>
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<td>• ACOG Patient Education: Combined Hormonal Birth Control: Pill, Patch, and Ring (FAQ185)</td>
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<td>• ACOG Patient Education: Emergency Contraception (FAQ114)</td>
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<td><a href="https://www.acog.org/patient-resources/faqs/contraception/emergency-contraception">https://www.acog.org/patient-resources/faqs/contraception/emergency-contraception</a></td>
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<td>• ACOG Patient Education: Long-Acting Reversible Contraception: Intrauterine Device and Implant (FAQ184)</td>
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<td>• ACOG Patient Education: Progestin-Only Hormonal Birth Control: Pill and Injection (FAQ186)</td>
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<tr>
<td>Sexually transmitted infections</td>
<td>• ACOG Committee Opinion No. 582 Addressing Health Risks of Noncoital Sexual Activity</td>
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<td><a href="https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2013/12/addressing-health-risks-of-noncoital-sexual-activity">https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2013/12/addressing-health-risks-of-noncoital-sexual-activity</a></td>
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<td></td>
<td>• Centers for Disease Control and Prevention’s Sexually Transmitted Diseases: Adolescents and Young Adults</td>
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*Because of time constraints, obstetrician–gynecologists may consider focusing on a few topics based on patient priorities. Obstetrician–gynecologists should use their best judgment about the questions to ask based on the patient’s maturity. Topics not covered can be addressed at future visits. An adolescent may receive care from multiple health care professionals (e.g., a pediatrician or family physician), so it is important to determine the level of reproductive health care and guidance already received and to work as a team with other health care professionals to ensure the provision of comprehensive reproductive health care. An assessment of the patient’s knowledge about reproductive health may be helpful.
wide variations in what is typical and a review of the supporting anatomy (eg, pelvic floor muscles).

**Timing, Scope, and Components of the Initial Visit**

The initial reproductive health visit should take place between the ages of 13 and 15 years. The scope of the initial visit will depend on the patient’s concerns, medical history, physical and emotional development, and the level of care the patient is receiving from other health care professionals. As individuals transition from childhood into young adulthood, there are physical, neurodevelopmental, psychological, and social developmental changes. From a developmental standpoint, these changes fit into three stages of adolescent development, classified as early, middle, and late adolescence (Table 2). It is important to recognize that growth in one area of development might not correspond with the patient’s chronological age; thus, anticipatory guidance should be offered based on a patient’s individual needs.

The primary goal of the initial reproductive health visit is to provide preventive health care services, educational information, and guidance, in addition to problem-focused care (Table 1). Obstetrician–gynecologists should ask a patient’s human papillomavirus (HPV) vaccination status, educate about the vaccine, and provide it, if appropriate. The visit allows patients and their parents or guardians the opportunity to visit the office, meet the obstetrician–gynecologist, alleviate fears, and develop trust. The obstetrician–gynecologist also can support the adolescent patients by providing the opportunity for them to participate in their own health care decisions and by reassuring them that their concerns will be addressed in a confidential setting, when possible. These are the first steps to help adolescent patients navigate their own health care. This may be the first time an adolescent has been asked to consider and participate in their own health care and begin to transition their health care away from the parent or guardian and to develop patient autonomy.

If the patient is sexually active or considering becoming sexually active, the obstetrician–gynecologist should provide counseling on contraception options, including emergency contraception and long-acting reversible methods (7). Many adolescents are at risk of engaging in unhealthy and risky behaviors such as alcohol, substance use, texting while driving, and tobacco and electronic cigarette use; these issues should be identified and addressed. Many youths are exposed to dating violence (8). It is important to screen for physical and sexual abuse, eating disorders, anxiety, and depression (Table 1). Screening for risk-taking behaviors can be facilitated by using a questionnaire as an alternative to direct interviewing; this can help guide which issues should be prioritized at the visit.

Adolescents with intellectual disabilities also require reproductive health care. Depending on the degree of disability or developmental delay, the obstetrician–gynecologist may need to engage in an in-depth discussion with the parent or guardian regarding menstruation, fertility, hygiene, options for menstrual manipulation and contraception, and how to keep the patient safe (9).

**Box 3. Sexual History Questions to Ask Patients**

- Who do you find yourself attracted to sexually or romantically? (Boys? Girls? Both? No one? Not sure?)
- Are you in a relationship with anyone?
- Are you having sex with anyone? If so, what kind of sex are you having?
  - How many sexual partners have you had in the past 3 months? In the last year?
  - Have you ever been diagnosed with a sexually transmitted infection (STI)?
  - How old were you the first time you had sex (intercourse)?
  - Have you ever had sex with a person of your same sex?
  - Are you having sex with someone who can get you pregnant?
  - Do you use anything to prevent pregnancy?
  - Do you use anything to prevent STIs? If yes, what do you use?
  - How often do you and your partner(s) use a condom when you have sex?
  - Do you use sex toys?
  - Do you ever feel pressured to have sex or has anyone interfered with your birth control?
  - Have you ever had sex for money or drugs?
  - Have you talked with your parents? How do your parents feel about this?
  - Do you ever participate in other sexual activities, such as touching or oral or anal sex?
  - If you are not having sex, are you thinking about having sex in the future?
  - Do you masturbate? Do you use something other than your hands?
  - Have you “ sexted”? Sent or received explicit pictures?
  - When, if ever, do you see yourself having children?
Table 2. Characteristic Behaviors of Adolescents

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Early</th>
<th>Middle</th>
<th>Late-to-Adulthood</th>
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<tbody>
<tr>
<td>Transition to adolescence</td>
<td>Essence of adolescence</td>
<td>Transition to adulthood</td>
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<tr>
<td>Characterized by puberty</td>
<td>Strong peer group influence</td>
<td>Take on adult role</td>
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<tr>
<td>Autonomy</td>
<td>Interested in the present and near future</td>
<td>Intellectual interests gain importance</td>
<td>Learn necessary vocational skills</td>
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<td>Vocational goals change frequently</td>
<td>Greater capacity for setting goals</td>
<td>Manage the demands of the labor market</td>
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<td>Body image</td>
<td>Rapid physical growth and body changes</td>
<td>Continuing physical and sexual changes</td>
<td>Greater acceptance of physical appearance</td>
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<td>Intense concern with body image</td>
<td>Sexual drives emerge</td>
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<td></td>
<td>Worries about being normal, menstruation, masturbation, breast size</td>
<td>Concern about sexual attractiveness</td>
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<td>Feelings of vulnerability and being “on stage”</td>
<td>Excessive physical activity alternating with lethargy and increased sleep</td>
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<td>Peer group</td>
<td>Argumentative—often challenge parents</td>
<td>Strong emphasis on the peer group</td>
<td>Greater balance between peer and family influence</td>
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<td>Still tend to be closely attached to parental figures</td>
<td>Strong peer alliances—fad behaviors</td>
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<td></td>
<td>Increasing influence and connection to peers</td>
<td>Increasing interest and involvement in intimate relationships/friendships</td>
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<td>Same-sex friends and group activities</td>
<td>Complaints that parents interfere with independence</td>
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<td>Beginning tendency to label or group peers (ie, cliques)</td>
<td>Conflict with family predominates because of ambivalence about emerging independence</td>
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<tr>
<td>Identity development</td>
<td>Identity influenced by relationships with family members, teachers, and peers</td>
<td>Refine identity around gender, physical attributes, sexuality, ethnicity</td>
<td>Clear sexual identity</td>
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<td></td>
<td>Daydreaming</td>
<td>Self-absorbed</td>
<td>Establish values about sexual behavior</td>
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<td></td>
<td>Reject things of childhood</td>
<td>Focused on examining their inner experiences (eg, journaling)</td>
<td>Develop skills for romantic relationships</td>
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<td></td>
<td>Often magnify their own problems</td>
<td>Continuing egocentrism; believes self to be invulnerable to negative events</td>
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<td>Begin to question and try out value systems</td>
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<tr>
<td>Cognitive and moral development</td>
<td>Understanding of cause and effect relationships is underdeveloped</td>
<td>Cause-effect relationships better understood</td>
<td>Established abstract thought and ethical principles</td>
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<td></td>
<td>Gradual development of the ability to apply what they’ve learned to new tasks</td>
<td>Reverts to concrete thought under stress</td>
<td>Formal operational thinking</td>
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<td>Frequent interest in learning life skills from adults</td>
<td>Growth in abstract thought</td>
<td>Sophisticated moral reasoning</td>
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<td></td>
<td>Primarily focused on the present.</td>
<td>Development of ideals and selection of role models</td>
<td>Philosophical and idealistic</td>
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<td>Sense of morality tends to be concrete, governed by conventional standards</td>
<td>Interest in moral reasoning</td>
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<td></td>
<td>Begin to identify with and internalize societal values</td>
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or pelvic pain) and that cervical cancer screening begins postadolescence (10–12). Many adolescents and their parents and guardians are unaware of the difference between a Pap test and a pelvic examination (13); thus, the obstetrician–gynecologist should provide guidance about these procedures and why they may be appropriate to perform at future visits.

If a physical examination is indicated (eg, in symptomatic patients or to provide education about anatomy and hygiene), the obstetrician–gynecologist should ask adolescent patients if they would prefer this portion of the examination be performed with or without a parent or guardian present. The American College of Obstetricians and Gynecologists recommends that a chaperone be in the room during the physical examination, as well as during diagnostic studies such as transvaginal ultrasonography (14). Patients should have autonomy regarding parent or guardian presence during examination, but a parent or guardian should not take the place of a chaperone (15). Patients should be counseled that they have the right to decline any examination.

Before completing an examination, the obstetrician–gynecologist should counsel the patient about what to expect for the physical examination portion of the visit, identify if there are patient concerns, and ask about the patient’s level of comfort. In some cases, a physical examination might be performed at a separate visit. When a gynecologic examination is performed, tanner staging of breast and pubic hair development should be evaluated and documented. During an external pelvic examination, the obstetrician–gynecologist can offer the option for patients to hold a mirror to educate themselves about their anatomy. Gentle traction on the labia majora usually allows for complete visualization of the hymen and vaginal orifice (Fig. 1). Selecting a speculum for the examination should be determined by the patient’s pubertal status, hymenal opening, and sexual experience. Offering to show an adolescent patient the speculum before the examination may be a useful way to provide education and reassurance. Typically, a narrow Pederson or Huffman speculum should be used. For patients with a history of trauma or gender dysphoria, a physical examination, particularly a gynecologic examination, might trigger anxiety; using a trauma-informed model of care that is collaborative and patient-driven can make the examination more manageable (16).

If patients are sexually active, annual screening for chlamydia and gonorrhea is recommended (17). Screening for STIs should be done in accordance with the Centers for Disease Control and Prevention’s guidelines for “Sexually Transmitted Diseases (STDs) Treatment and Screening” at https://www.cdc.gov/std/treatment/default.htm. When appropriate, the health care professional should consider screening with a urine sample or an oral, vaginal or anal swab. Self-collected swabs (versus samples taken by a health care professional) may be a reasonable alternative if preferred by the patient. The Centers for Disease Control and Prevention and the American College of Obstetricians and Gynecologists recommend that patients aged 13–64 years be tested for human immunodeficiency virus (HIV) at least once in their lifetime and annually thereafter based on factors related to risk (18). Trichomonas screening can be considered for patients receiving care in high prevalence settings (eg, an STI clinic), those with a high risk for infection (eg, multiple sex partners, a history of STI), and with presenting concerns of vaginal discharge (17).

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Management and Follow-Up

At the completion of the physical examination, the health care professional should address physical findings, diagnosis, and potential treatment options. Once a treatment plan has been mutually decided upon, the adolescent is encouraged to include the parent or guardian in the management plan. It is critical to assess what information can and cannot be shared with the parent or guardian. At the conclusion of the visit, the patient, parent or guardian, and obstetrician–gynecologist should discuss the findings and recommendations. Any remaining concerns can be addressed, and the parent or guardian can be offered guidance on adolescent development. Follow-up should be individualized and determined by the patient’s needs. Adolescents may benefit from close follow-up for questions and support regarding adherence to contraception (19). Some adolescents will be seen on an annual basis because their needs will change with age; others who need problem-solving care may require closer follow-up; discussing future visit expectations is appropriate. Obstetrician–gynecologists have the opportunity to serve as educators of parents and guardians about reproductive health issues. Resources should be provided for both the adolescent patient and the parent or guardian, if possible, at the conclusion of the visit.

References


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