MedStar Health
Ambulatory Best Practice Group
Recommended Screening Guidelines for Adults 2025

"These guidelines are provided to assist physicians and other clinicians in making decisions regarding the care of their patients. They are not a substitute for individual judgment brought to each clinical situation by the patient's primary care provider in collaboration with the patient. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication but should be used with the clear understanding that continued research may result in new knowledge and recommendations".

This document is a summary of some recommendations for the appropriate screening of adult patients by primary care practitioners in the MedStar Health system. In each of the sections the recommendations are alphabetized. Note that the provision of preventive services may occur in a periodic health maintenance visit devoted to screening, counseling and prevention or be incorporated into follow up or urgent visits based on patient and clinician preferences and office workflows.

Adult Populations

Preventive Service	Guideline
Personalized Recommendations per USPSTF	▪ To offer any patient, for age, gender, and risk factor-based recommendations and level of evidence, see **Electronic Preventive Services Selector**; ▪ *The **grade-definitions** used for this guideline are as defined by the United States Preventive Services Task Force (USPSTF).*
Abdominal Aortic Aneurysm[1, 66, 86-87]	**USPSTF**[1] ▪ For men aged 65-75 who have ever smoked: One-time screening for abdominal aortic aneurysm by ultrasonography **[B]** ▪ For men aged 65-75 who have never smoked: Selectively offer screening for abdominal aortic aneurysm by ultrasonography based on patient's medical history, family history, other risk factors and personal values. **[C]** ▪ For women aged 65-75 who have ever smoked or have a family history of AAA: evidence for screening for AAA is insufficient **[I]** ▪ For women aged 65-75 who have never smoked and have no family history of AAA: Do not screen for AAA **[D]** **Net benefit estimates are driven by biologic sex (i.e., male/female) rather than gender identity.* **Definition: "ever smoker" as someone who has smoked at least 100 or more cigarettes in their lifetime.* **ACC/AHA** Aortic Disease Screening recommends: ▪ Ultrasound screening for AAA is recommended in men ≥65 years who have ever smoked and in men or women ≥65 years with a first-degree relative with AAA(COR-1). Ultrasound screening is reasonable in women ≥65 years who have ever smoked (COR-2a). In men or women <65years of age with multiple risk factors (Strong risk factors: male; older age; smoking; family history of AAA; ASCVD; Additional risk factors: Hypertension, hyperlipidemia; white race; inherited vascular connective tissue disorder; or first degree relative with AAA ultrasound screening for AAA may be considered (COR-2b).[66.] **The Society of Vascular Surgery** (SVS) recommends: ▪ Screening men and women ages 65 to 75 years with either a history of smoking or a family history of AAA, as well as men and women over the age of 75 with a smoking history in otherwise good health who have not previously undergone screening.[66,86,87]

Initial Approval Date and Reviews:	**Most Recent Revision and Approval Date:**	**Next Scheduled Review Date:**
By 2010, 01/12, 01/14, 01/15, 01/16, 01/17, 01/18, 01/19, 01/20, 3/20 (interim update), 1/21, 3/21 (interim update), 6/21 (interim update), 1/22, 1/23, 1/24, 5/24 (interim update); 1/2025 Ambulatory Best Practice Committee	**January 2025** 	January 2026 Ambulatory Best Practice Committee

Anal Cancer Screening [79-81, 109, 110-112]	**USPSTF:** ▪ The Task Force has deferred evidence review of this topic at this time. **HIV Guidelines/ NIH Office of AIDS Research** Expert Panel in HIV Care: ▪ All adults with HIV be assessed at least once per year for anal abnormalities (such as unexplained itching, anal bleeding, or pain; presence of perianal lesions) and undergo digital anorectal examination (DARE). ▪ People under the age of 35 who are symptomatic or show signs of anal cancer (visual or palpable abnormalities) during DARE should undergo standard anoscopy. ▪ Older people should undergo additional lab-based screening with subsequent High Resolution Anoscopy (HRA), rather than standard anoscopy, if they are among the following populations: • Men who have sex with men and transgender women ages 35 and older **(AII)** • All other people with HIV ages 45 and older **(AII)** ▪ MSM and transgender women aged 35 years and older, and other people with HIV aged 45 years and older, should continue to be assessed annually for anal symptoms and undergo DARE regardless of symptoms **(BIII).** ▪ This lab-based screening can be performed using *anal cytology alone or with hr-HPV co-testing*. If there are any abnormalities on those specimens, or symptoms or signs of anal cancer in the initial assessment and DARE, clinicians should make a referral for HRA. ▪ Currently are no FDA-cleared anal HPV tests, but testing is available in many clinical laboratories. It is strongly recommended to use only clinical laboratories that have undergone CLIA certification to conduct anal HPV tests. ▪ If cytology will be obtained for screening, defer DARE until after swabbing anal canal to decrease potential for lubricant interfering with cytology results. ▪ Until further data on screening algorithms are available, the recommended screening approaches include: ▪ Figure 3. Screening Algorithm for Anal Cancer in Asymptomatic People With HIV ▪ Figure 4. Assessment of Anal Cytology and HPV Results in People With HIV ▪ High-priority patients if HRA availability limited: Higher grade of cytologic abnormality; HPV16 on HPV testing Smokers; >60 years of age; Longer known duration of HIV/ History of AIDS. **International Anal Neoplasia Society (IANS) consensus guidelines:** Risk Category A: (10 times more likely to develop anal cancer over the general populations at the listed ages) ▪ Persons with HIV: • ≥35 years - men who have sex with men (MSM) and transgender women (TW) • ≥45 years of age–HIV + patients (non-MSM/TW) ▪ ≥45 years of age MSM and TW without HIV infection ▪ Solid organ transplant recipients–screening should begin 10 years post transplantation ▪ History of vulvar pre-cancer or cancer–screening starts within one year of diagnosis

	Risk Category B: Risk Category B (incidence less than 10-fold higher than the general population) ***Shared decision-making recommended Age 45+:*** ▪ Cervical/Vaginal HSIL/Cancer ▪ Perianal warts ▪ Persistent HPV16+(>1year) ▪ Other immunosuppression or on chronic systemic steroid therapy Perform Digital Anal Rectal Exam + Anal cytology and/or anal HPV testing ▪ Abnormal result→High resolution anoscopy ▪ Normal result→repeat screen in 1-2 years Inquire as to whether at-risk patients have received the HPV vaccine. [90]
Anxiety Disorder in Adults:[96, 103]	**USPSTF recommends:** ▪ Screening for anxiety disorders in adults 64years or younger, including pregnant and postpartum persons [B] and concludes insufficient evidence to assess the balance of benefits and harms of screening for anxiety disorder in adults 65years or older [I] ▪ More evidence needed regarding optimal timing for screening, or screening interval, for both the perinatal and general adult populations. Adequate systems and clinical staff are needed to ensure that patients are screened with valid and reliable screening tools; positive screening results should be confirmed by diagnostic assessment and patients should be provided, or referred to evidence based care which should be accessible to all patients. **ACOG:** ▪ The American College of Obstetricians and Gynecologists recommends screening patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool. Clinicians are recommended to complete a full assessment of mood and emotional well-being (including screening for postpartum depression and anxiety with a validated instrument) during the comprehensive postpartum visit for each patient.
Aspirin chemoprevention [2-6]	**USPSTF** recommends: ▪ decision to initiate low-dose aspirin use for the primary prevention of CVD in adults aged 40 to 59 years who have a 10% or greater 10-year CVD risk should be an individual one. **[C]** • Evidence indicates that the net benefit of aspirin use in this group is small. Persons who are not at increased risk for bleeding and are willing to take low-dose aspirin daily are more likely to benefit. Annual bleeding events in individuals without risk factors for increased bleeding (e.g., history of gastrointestinal bleeding risk, history of peptic ulcer disease, or use of nonsteroidal anti-inflammatory drugs or corticosteroids) are rare, but risk for bleeding increases modestly with advancing age. For persons who have initiated aspirin use, the net benefits continue to accrue over time in the absence of a bleeding event however become progressively smaller with advancing age because of an increased risk for bleeding, with data suggesting that it may be reasonable to consider stopping aspirin use around age 75 years. ▪ USPSTF recommends against initiating low-dose aspirin use for the primary prevention of CVD in adults ≥60years. **[D]** ▪ USPSTF concluded that the evidence is inadequate that low-dose aspirin use reduces CRC incidence or mortality.

	ACC/AHA recommend: ▪ Low-dose aspirin use (75 to 100mg/d) might be considered for the primary prevention of ASCVD among select adults 40 to 70 years of age who are at higher ASCVD risk but not at increased bleeding risk. [67,68,71.] ▪ Low-dose aspirin use is not recommended on a routine basis for primary prevention of CVD in adults older than 70 years or among adults of any age who are at increased risk of bleeding. **Women's Health:** • USPSTF & ACOG recommend: Prophylactic low-dose aspirin after 12 weeks of gestation in persons who are at high risk. for preeclampsia and should be considered in those at moderate risk **[B]**. [67,68]
Asymptomatic Bacteriuria in Adults [88]	**USPSTF:** ▪ Screen pregnant persons for asymptomatic bacteriuria using a midstream, clean-catch urine culture at 12 to 16 weeks of gestation or the first prenatal visit or, whichever is earlier. A urine culture showing >100,000 CFU/mL of a single uropathogen or >10,000 CFU/mL if the pathogen is group B streptococcus is an indicator of vaginal colonization and is commonly used as the threshold for treatment of infection in pregnancy. **[B]** ▪ Do not screen adults who are not pregnant for asymptomatic bacteriuria. [D]
Blood Pressure [7-8]	**USPSTF** recommends: ▪ Screening for hypertension in adults 18 years or older without known hypertension with office blood pressure measurement (OBPM). They recommend obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation with validated and accurate home blood pressure monitoring (HBPM) or Ambulatory blood pressure monitoring (ABPM) before starting treatment. **[A]** ▪ The USPSTF suggests annual screening for hypertension in adults 40 years or older and for adults at increased risk for hypertension (such as Black persons, persons with high-normal blood pressure, or persons who are overweight or obese). Screening less frequently (i.e., every 3 to 5 years) is appropriate for adults aged 18 to 39 years not at increased risk for hypertension and with a prior normal blood pressure reading. ▪ Screen all pregnant women and pregnant persons of all genders for hypertensive disorders of pregnancy with blood pressure measurements at each prenatal care visit throughout pregnancy. **[B][95]** **ACC/AHA** guideline recommends: ▪ Annual screening for HTN in all normotensive patients (BP < 120/80) with more frequent monitoring and management for patients with higher blood pressure readings. They also suggest screening for masked hypertension with ABPM or HBPM in adults who consistently have systolic blood pressure measurements of 120 to 129 mm Hg or diastolic blood pressure measurements of 75 to 79 mm Hg in the office[7,28] and screening for white coat hypertension in adults who consistently have systolic blood pressure measurements of 130 to 160 mm Hg or diastolic measurements of 80 to 100 mm Hg in the office.

Breast Cancer Screening in average risk women and transgender men who have not undergone "top" surgery: Breast self-exam Clinical Breast exam Mammography [9-13]	**USPSTF:** ▪ **Breast self-exam (BSE) [10-13]:** Breast self-examination is not recommended in average-risk women because there is a risk of harm from false-positive test results and a lack of evidence of benefit. **[D]**; Average-risk women should be counseled about breast self-awareness. The importance of promptly reporting changes, such as pain, a mass, new onset of nipple discharge, or redness in their breasts to a physician is emphasized.[73] ▪ **Clinical Breast Exam:** The USPSTF and the ACS do not routinely recommend Clinical Breast Exam (CBE) in average risk women at any age without breast symptoms or abnormalities, based on insufficient evidence. **[I]** ▪ **Mammography:** The USPSTF recommends biennial screening mammography for women aged 40-74years [B] ▪ For women > 75 years of age, the decision to continue screening should be individualized. Screening should be discontinued for women with a life expectancy <10 years. **[I]** ▪ USPSTF states insufficient evidence to recommend adjunctive screening for breast cancer using breast ultrasonography, magnetic resonance imaging, or other methods in women identified to have dense breasts on an otherwise negative screening mammogram. **[I]** ▪ These recommendations apply to persons who have factors associated with an increased risk of breast cancer, such as a family history of breast cancer (i.e., a first-degree relative with breast cancer) or having dense breasts. They do not apply to persons who have a genetic marker or syndrome associated with a high risk of breast cancer (e.g., *BRCA1* or *BRCA2* genetic variation), a history of high-dose radiation therapy to the chest at a young age, or previous breast cancer or a high-risk breast lesion on previous biopsies.
Breast Cancer: Risk assessment and Risk Reduction [14-15]	**Risk assessment:** ▪ USPSTF recommends women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with BRCA 1 / 2 gene mutations should be assessed with an appropriate brief familial risk assessment tool. Those with a positive result should receive genetic counseling, and if indicated, genetic testing. **[B]** ▪ Suitable validated screening tools that can accurately estimate the likelihood of carrying a harmful BRCA1/2 mutation include the Ontario Family History Assessment Tool, Manchester Scoring System, Referral Screening Tool, Pedigree Assessment Tool, 7-Question Family History Screening Tool, Tyrer-Cuzick tool and brief versions of BRCAPRO. General breast cancer risk assessment models (e.g., the National Cancer Institute Breast Cancer Risk Assessment Tool, which is based on the Gail model) are not designed to identify *BRCA*-related cancer risk and should not be used for this purpose. **Risk Reduction:** ▪ USPSTF: Clinicians should offer to prescribe risk reducing medications such as tamoxifen, raloxifene or aromatase inhibitors to women aged 35years or older at increased risk for breast cancer and at low risk for adverse medication effects. **[B]** Use of raloxifene and aromatase inhibitors is indicated only in postmenopausal women; only tamoxifen is indicated for risk-reduction of primary breast cancer in premenopausal women.

Cervical Cancer Screening & Prevention in average and high-risk women and transgender men who have a cervix. [16,17,18,106]	**USPSTF:** ▪ Screening for Cervical cancer should begin at age 21 years (regardless of sexual history or HPV vaccination history). *Screening before age 21 should be avoided because women less than 21 years old are at very low risk of cancer.* **[D]** *Screening these women may lead to unnecessary and harmful evaluation and treatment* (ACOG 2009). ▪ Women from ages 21 to 29 should be screened every three years, using cervical cytology alone. **[A]** ▪ Women ages 30-65 may be screened once every three years with either cervical cytology alone OR every 5 years with high-risk human papillomavirus (hrHPV) testing alone or every 5 years with co-testing (cytology + hrHPV test administered together) **[A]** ▪ USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer. **[D]** As part of the clinical evaluation clinicians should confirm through review of surgical records or direct examination that the cervix was removed. ▪ The USPSTF recommends against screening for cervical cancer in women older than 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer. **[D]** ▪ Adequate prior screening is defined as 3 consecutive negative cytology results or 2 consecutive negative co-testing results within 10 years before stopping screening, with the most recent test occurring within 5 years. ▪ Screening should continue for at least 25 years after spontaneous regression or appropriate management of a precancerous lesion, even if this extends screening past age 65 years. ▪ Once screening has stopped, it should not resume in women older than 65 years, even if they report having a new sexual partner. ▪ Women with HIV, post solid organ or hematopoietic stem cell transplants, with SLE, with Rheumatoid Arthritis or Inflammatory Bowel Disease on immunosuppressants, who were exposed to diethylstilbestrol (DES) in utero, or who have been treated for cervical intraepithelial neoplasia (CIN)2, CIN 3 or cervical cancer are not average risk and should be screened more frequently. Screening for **Cervical abnormalities in HIV** [78, 79] ▪ Additional recommendations for Cervical Cancer prevention: Centers for Disease Control and Prevention's Advisory Council on Immunization Practice recommends routine HPV vaccination. (See Immunization Section). ▪ The USPSTF found insufficient evidence to assess the balance of benefits and harms of performing screening pelvic examinations in asymptomatic women for the early detection and treatment of a range of gynecologic conditions [I] ****NOTE: USPSTF draft update (Dec 10, 2024), when finalized is consistent with the 2018 recommendation except that this draft includes a recommendation that high-risk HPV primary screening every 5 years is the preferred screening strategy starting at the age of 30 years and now includes option for patient-collected HPV screening.** ACS: ▪ American Cancer Society recommends that individuals with a cervix initiate cervical cancer screening at age 25 years and continue testing every 5 years through age 65 years. If primary HPV testing is not available, it recommends testing every 5 years with cotesting or every 3 years with cytology alone. It also recommends that individuals older than age 65 years with no history of CIN2+ and adequate prior screening discontinue screening.

Chlamydia & Gonorrhea Infection[19]	**USPSTF recommends screening in:** ▪ Sexually active women including pregnant persons, aged 24 years and younger and asymptomatic women 25years and older who are at increased risk for infection (those who have a new or more than 1 sex partners or a sex partner with concurrent partners or a sex partner who has an STI, practice inconsistent condom use when not in a mutually monogamous relationship or have a previous or coexisting STI; exchanging sex for money or drugs and history of incarceration) **[B]** ▪ Insufficient evidence to assess balance or benefits and harms of screening for gonorrhea & chlamydia in men. [I] ▪ For additional information, see section: STI Screening in Special Population
Cholesterol Screening[21, 75, 91,]	▪ The age at which screening should begin should be based on an individual's other cardiac risk factors and desire to be screened. Screening may begin in non-pregnant adults at any age but no later than age 40 (the age at which statin therapy for primary prevention is recommended). The development of diabetes or clinical ASCVD should prompt evaluation as well. ▪ 10-year risk should be re-evaluated every 4-6 years between the ages of 40 and 75. ▪ For adults 20 to 39 years of age, ACC/AHA believes that it is reasonable to assess traditional ASCVD risk factors at least every 4 to 6 years. ▪ For adults 20 to 39 years of age and for those 40 to 59 years of age who have <7.5% 10-year ASCVD risk estimating lifetime or 30- year ASCVD risk may be considered. ▪ Screening may be done with either a fasting lipid profile or non-fasting total cholesterol and HDL measurement. If a non-fasting measurement reveals a triglyceride value >400, a fasting lipid profile should be measured.
Cholesterol: Statin use for Primary Prevention of CVD in Adults: Preventive Medication [20, 21, 75, 101]	**USPSTF recommends:** ▪ statin be prescribed for primary prevention of CVD for adults aged 40-75 years who have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year risk if a CV event of 10% or greater. **[B]** ▪ For statins to be selectively offered if estimated 10-year risk of a cardiovascular event of 7.5 to less than 10%. **[C]** ▪ Current evidence being insufficient to assess the balance of benefits and harms of initiating a statin for the primary prevention of CVD events and mortality in adults 76 years or older. **[I]** ▪ These recommendations do not apply to adults with a low-density lipoprotein cholesterol (LDL-C) level greater than 190 mg/dL (4.92 mmol/L) or known familial hypercholesterolemia. **ACC/AHA guidelines:** ▪ Define cardiovascular risk categories as high (10-year risk of cardiovascular events ≥20%), intermediate (10-year risk of cardiovascular events ≥7.5% to <20%), and borderline (10-year risk of cardiovascular events 5% to <7.5%). The guidelines recommend initiation of statin therapy in persons at intermediate or high risk and a risk discussion for persons at borderline risk, and recommend consideration of risk enhancers to refine risk assessments based on the Pooled Cohort Equations and inform decision-making for persons at intermediate and borderline risk.[75] The risk enhancers include family history of early coronary heart disease, presence of chronic kidney disease, metabolic

	syndrome, preeclampsia, premature menopause, inflammatory diseases, HIV, and South Asian ancestry. ▪ **ACC/AHA Risk Calculator** ▪ Recently published American Heart Association **Predicting Risk of cardiovascular disease EVENTs** (**PREVENT**™) ▪ This calculator is derived and validated in over 6.6 million adults to estimate 10- and 30-year risks of CVD and its subtypes, heart failure and ASCVD. The inputs include standard CVD risk measures (e.g., age, sex, body mass index, diabetes, lipid levels, smoking history, blood pressure, and kidney function); the full model also includes albuminuria, hemoglobin A1C, and zip code (which estimates social deprivation).
Cognitive Impairment in older adults[23]	USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for cognitive impairment in older adults. **[I]**
Colorectal Cancer Screening[25-27]	**USPSTF and the American Cancer Society recommend:** ▪ Beginning at age 45-49 years **[B]** and in all adults 50-75years of age [A], both men and women at *average risk* for developing colorectal cancer should be offered one of the screening tests below**.** The tests that are designed to find both early cancer and polyps are preferred if these tests are available, and the patient is willing to undergo one of these more invasive tests. **Tests that find polyps and cancer** (**Direct Visualization Tests):** ▪ Colonoscopy every 10 years ▪ Flexible sigmoidoscopy every 5 years* ▪ CT colonography (virtual colonoscopy) every 5 years* (consider community availability) ▪ Combination Flex sig every 10 yrs. with annual FIT testing* **Tests that mainly find cancer** (Stool-based Tests) * ▪ High sensitivity gFOBT every year, **, *** ▪ Fecal immunochemical test (FIT) every year *** ▪ FIT- DNA test (sDNA-FIT), q 1 to 3 years. *Colonoscopy should be done if test results are positive. **If high sensitivity gFOBT is used as a screening test, the take-home multiple sample method should be used. Requires dietary restrictions, High sensitivity. versions (e.g., Hemoccult SENSA) have superior test performance characteristics than older tests (e.g., Hemoccult II) ***A high sensitivity gFOBT or FIT done during a digital rectal exam in the doctor's office is not adequate for screening. ▪ The USPSTF recommends against screening in adults older than age 85; they recommend that decisions between ages 75-85 should be individualized based on prior screening and overall health risks **[C].** ▪ Screening should be considered earlier and/or more often for individuals with any of the following colorectal cancer risk factors: personal Hx of colorectal cancer, a personal history of chronic inflammatory bowel disease (Crohn's disease or ulcerative colitis), a strong family history of colorectal cancer or polyps (cancer or polyps in a first-degree relative [parent, sibling, or child] younger than 60 or in 2 or more first-degree relatives of any age), a known family history of hereditary colorectal cancer syndromes such as familial adenomatous polyposis (FAP) or Lynch syndrome.

	▪ Patients for whom there is concern for a hereditary or genetic colorectal cancer syndrome may be referred for genetic counseling and possible testing if available. * Blood-based tests have not yet been incorporated into clinical guidelines for first-line colorectal cancer screening.
Counseling [29-38, 92,93, 104, 107]	**Family history collection is important in primary care to identify and manage individuals at increased risk for various diseases.** The history should be as detailed as possible and include: ▪ Current ages or ages at death for relatives ▪ Occurrences of chronic diseases, such as cancer and heart disease (type, age at diagnosis) ▪ Information on first-, second- and third-degree relatives as possible **For all adults, screen using appropriate screening tools for the following conditions not covered elsewhere:** ▪ Birth control/sexual behavior—assess the person's risk for acquiring STIs; aim to increase motivation or commitment to safer sex practices, and provide training in condom use, communication about safer sex. **[B]** ▪ Violence detection/counseling ▪ Dental health Oral Health in Adults: Screening and Preventive Interventions: USPSTF concluded that the current evidence is insufficient to assess the balance of benefits and harms of routine screening & preventive intervention performed by primary care clinicians for oral health conditions, including dental caries or periodontal-related disease, in adults. **[I]** ▪ Smoking—Tobacco cessation is a high priority intervention from a health and cost-effectiveness standpoint. USPSTF recommends that clinicians ask all adults, about tobacco use, advise them to stop using tobacco, and smokers should be offered pharmacologic therapy with proven effectiveness and established safety and behavioral interventions. **[A]**; Current evidence is insufficient to assess the balance of benefits and harms of electronic cigarettes (e-cigarettes) for tobacco cessation in adults, including pregnant persons. **[I]** Per GOLD 2024 Based on the available evidence, and the lack of knowledge about the long-term effects of e-cigarettes on respiratory health, it is not possible to recommend this intervention for smoking cessation in patients with COPD. ▪ Diet/nutrition— Dietary guidelines from both the U.S. Department of Health and Human Services and the ACC/AHA recommend following a healthy eating pattern that consists of a variety of vegetables, whole fruits, legumes, nuts, whole grains, and fish while minimizing intake of added sugars, saturated and trans fats, sodium, and refined carbohydrates. Recommend water as the drink of choice. ▪ Exercise— at least 150 minutes of moderate intensity or 75 minutes of vigorous intensity exercise per week in addition to engaging in strengthening activities at least twice per week. ▪ Fall/ Injury Prevention— including seat belt use, use of safety helmets for motorcycles and bicycles, and home safety measures, should be emphasized. Advise use of smoke alarms in the home and to set water heaters to lower than 49 ^{0}C (120 ^{0}F) in households with infants and young children. The USPSTF recommends exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls. **[B];** individualize the decision to offer multifactorial interventions as these have a small benefit in preventing falls and fall-related morbidity in older adults at increased risk for falls. [C] ▪ Caregiver abuse of older or vulnerable adults: Insufficient evidence to screen. **[I]**; Risk factors for elder abuse include isolation and lack of social support, functional impairment, and poor physical health. For older adults, lower income and living

in a shared living environment with a large number of household members (other than a spouse) are associated with an increased risk of financial and physical abuse. No valid, reliable screening tools in the primary care setting to identify abuse of older or vulnerable adults without recognized signs and symptoms of abuse.

- Skin Protection—particularly for adults less than 24 years of age and with fair skin types **[B];** Selectively offer counseling about minimizing exposure to UV radiation to adults older than 24years with fair skin type. **[C]**; Consider presence of risk factors for skin cancer in determining if counseling appropriate e.g., Persons who use tanning beds and those with a history of sunburns or previous skin cancer are also at greatly increased risk of skin cancer. Other factors that increase risk include an increased number of nevi (moles) and atypical nevi, family history of skin cancer, HIV infection, and history of receiving an organ transplant. Insufficient evidence to counsel self-skin examination. [I]
- STI Prevention: USPSTF: Behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs) **[B]**

USPSTF recommends:

- Screen for intimate partner violence. Pregnant or postpartum persons and women of reproductive age **[B]** Women who screen positive should be provided or referred for appropriate interventions. Available screening tools include the Hurt, Insult, Threaten, Scream (HITS); Ongoing Abuse Screen/Ongoing Violence Assessment Tool (OAS/OVAT); Slapped, Threatened, and Throw (STaT); Humiliation, Afraid, Rape, Kick (HARK); Modified Childhood Trauma Questionnaire-Short Form (CTQ-SF); and Woman Abuse Screening Tool (WAST). **Domestic Violence Hotline Local Resources**

- Folic Acid Supplementation[100]: Advise women planning or capable of pregnancy to take a folic acid supplement of 0.4-0.8 mg (400-800 mcg) daily **[A]**

Alcohol use screening and counseling:

- Unhealthy alcohol use: All adults aged 18 and over, including pregnant women should be screened for unhealthy alcohol use **[B]** using the AUDIT-C or single question screening tool. Patients who screen positive for risky or hazardous drinking should receive brief behavioral counseling interventions. Patients with alcohol abuse or dependence should be referred for specialty treatment. Risky drinking is defined as more than 4 drinks per day or 14 drinks per week for men ages 21-64 and more than 3 drinks per day or 7 drinks per week for women of any age and men 65 or older; any alcohol use by pregnant women; any alcohol use by people younger than age 21yrs.
- Individuals who do not drink alcohol should not be advised to start.
- Individuals who already drink alcohol should be advised to drink in moderation--for women ≤ 1 drink/day and for men ≤ 2 drinks per day. *
- Alcohol consumption has been associated with an increased risk of developing hypertension and cancer (including breast, colorectal, liver, stomach and aerodigestive)
- There is evidence that moderate alcohol consumption may be protective in at least some people against coronary artery disease.
- A standard drink is defined as 5 ounces of wine, 12 ounces of beer or 1.5 ounces of distilled spirits.

	Drug Screening & Counseling: ▪ Unhealthy use of other drugs: All adults aged 18 and should be screened for unhealthy drug use by asking questions (not testing biological specimens). **[B]**; A one sentence screening question: "How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?" is highly sensitive and specific both for drug use in the past year as well as a drug use disorder. ▪ Multiple other screening tools including the NIDA Quick Screen (4 questions), or longer tools (such as ASSIST) are also available. **Obesity:** ▪ All patients who are overweight or obese should undergo counseling on the benefits of a health weight, regular exercise, and a healthy diet. Refer adults with a BMI of 30 or more to intensive multi-component behavioral counseling. **[B]** **Adults with cardiovascular disease (CVD) risk factors:** ▪ The USPSTF recommends offering or referring adults with CVD risk factors to behavioral counseling interventions to promote a healthy diet and physical activity. **[B]**
Diabetes Mellitus and Pre-Diabetes [39, 40]	**USPSTF recommends:** ▪ Screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 35 to 70 years who are overweight or obese; to refer patients with prediabetes to effective preventive interventions. **[B]** ▪ Screening at an earlier age should be considered for those with a family history of diabetes, personal history of PCOS or gestational diabetes, or who are members of high-risk ethnic groups. ▪ USPSTF recommends screening for gestational diabetes in asymptomatic pregnant persons at 24 weeks of gestation or after. **[B]** **American Diabetes Association recommends:** ▪ All individuals 35 years and older be screened for diabetes and pre-diabetes. ▪ Testing should be considered in all adults who are overweight (BMI≥25 kg/m2 or ≥23 kg/m2 in Asian Americans) who have one or more additional risk factors: • 1st degree relative with diabetes. • High-risk ethnic group (African American, Latino, Native or Asian Americans, Pacific Islanders. • Physically inactive. • Hypertension (≥130/90) or on therapy for hypertension. • PCOS (polycystic ovary syndrome). • Plasma high-density lipoprotein cholesterol level <35 mg/dl or triglyceride level >250 mg/dl. • History of CVD. • Other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans, metabolic dysfunction–associated steatotic liver disease) ▪ Women planning pregnancy who are overweight or obese and/or have one or more additional risk for diabetes should be screened for diabetes and pre-diabetes.

	▪ Patients with HIV should be screened for diabetes and pre-diabetes with a fasting glucose test before starting antiretroviral therapy, at the time of switching antiretroviral therapy, and 3-6 months after starting or switching antiretroviral therapy. If initial screening results are normal, fasting glucose should be checked annually. ▪ People with exposure to high-risk medicines (e.g., glucocorticoids, statins, PCSK9 inhibitors, some HIV medicines, second generation antipsychotic medications), history of pancreatitis. People treated with these agents should be screened for prediabetes or diabetes at baseline, rescreened 12–16 weeks after medication initiation, and screened annually thereafter. ▪ The **ADA Diabetes Risk Test** is a tool which may be used to assess appropriateness of screening. **Screening Methods**: ▪ Fasting plasma glucose, 2 hr. plasma glucose following 75 gm OGTT or A1C are equally acceptable modalities. **Screening Frequency**: ▪ Re-screening should occur at a minimum every 3 years if results are normal with more frequent screening based on individual results and risk. ▪ Individuals with pre-diabetes (A1C 5.7-6.4%), impaired glucose tolerance (140-199 mg/dl) or impaired fasting glucose (100-125 mg/dl) should be tested annually. ▪ People who were diagnosed with GDM should have testing at least every 1–3 years ▪ Women with a history of gestational diabetes mellitus found to have prediabetes should receive intensive lifestyle interventions and/or metformin to prevent diabetes.
Depression & Suicide Risk in Adults: Screening[41]	**USPSTF recommends:** ▪ Screening for depression in the general adult population, including pregnant and postpartum persons as well as older adults (≥65years). **[B]** USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for suicide risk in the adult population, including pregnant and postpartum persons, as well as older adults. [I] ▪ The USPSTF recommends screening for depression in all adults regardless of risk factors. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment & appropriate follow-up. The patient may complete screening during the office visit with a patient self-reported questionnaire or using one of the various screening measures that have been specifically designed to detect depression. Physicians can choose the screening measures that are appropriate for their patients and practice setting and for monitoring change in patients who are receiving treatment for depression. All positive screening results should lead to additional assessments to confirm the diagnosis, determine symptom severity, and identify comorbid psychological problems.
Eye Disease Screening[42]	▪ The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for impaired visual acuity in older adults. [I] ▪ American Academy of Ophthalmology: Baseline screening should start at age 40 for adults with no signs or risk factors for eye disease. Patients of any age with eye disease risk factors, such as high blood pressure, family history or diabetes, should consult with their ophthalmologist about frequency of eye exams.

	▪ ADA: Eye examinations should occur before pregnancy or in the first trimester in patients with preexisting type 1 or type 2 diabetes, these patients should be monitored every trimester and for 1 year postpartum as indicated by the degree of retinopathy. [B] [85]
Hearing [43,44]	▪ USPSTF found insufficient evidence to recommend screening for hearing loss in asymptomatic adults 50years or older. [I] Providers should perform subjective hearing screening periodically with counseling on hearing aid devices and making referrals as appropriate.
Height and Weight[31], BMI	▪ Baseline height, weight and BMI are indicated for all adults 18 years of age and older annually; Weight Reduction Counseling should be recommended for all patients with BMI > 25kg/m^2; USPSTF recommends that clinicians offer or refer adults with a BMI of 30 or higher to intensive, multicomponent behavioral interventions designed to help participants achieve or maintain a 5% or greater weight loss through a combination of dietary changes and increased physical activity. **[B]**; Nutrition counseling should be given to those who are underweight (BMI < 18.5 kg/m2). ▪ The ACC/AHA and the Obesity Society recommend annual screening with BMI and waist circumference measurements.
Hepatitis B Screening[45, 102]	**USPSTF recommends:** ▪ Screening for hepatitis B virus infection in adolescents and adults at increased risk for infection using HBsAg testing. **[B]** Persons at increased risk include: ▪ Persons who have used intravenous drugs in the past or currently. ▪ Men who have sex with men ▪ HIV infected persons ▪ Sexual partners or household contacts of hepatitis B infected persons ▪ Needle-sharing contacts ▪ Adults and adolescents born in countries with ≥ 2% prevalence of hepatitis B ▪ Adults and adolescents born in the US and who did not receive the hepatitis B vaccine as children and who are children of parents born in countries with ≥ 8% prevalence of hepatitis B (Link to Countries with moderate and high prevalence of Hepatitis B) ▪ Clinical judgment should be used to determine screening frequency. ▪ Screening is recommended for pregnant women at their first prenatal visit. **[A]** **CDC recommendation:** ▪ Adults with no known risk factors for hepatitis B-if never previously screened, test for HBsAg, anti-HBs and total anti-HBc (triple panel) ▪ Vaccinate adults aged 18-59 years.
Hepatitis C Screening [46,47]	**USPSTF recommends:** ▪ Screening all adults 18-79 for hepatitis C one time. Persons at continued risk (persons with past or current injection drug use) should be screened periodically. **[B]**

HIV Testing [48-49] HIV Pre-exposure Prophylaxis (PrEP) [50]	**USPSTF:** **Screening:** ▪ Testing for HIV infection should be performed routinely for all patients aged 15--65 years. Younger adolescents and older adults who are at increased risk of infections should also be screened. USPSTF recommends clinicians screen for HIV infection in all pregnant persons, including those who present in labor or at delivery whose HIV status is unknown. **[A]** ▪ High risk patients include: injection-drug users and their sex partners, unprotected anal or vaginal intercourse with more than 1 partner whose HIV status is unknown, persons who exchange sex for money or drugs (transactional sex), sex partners of HIV-infected persons, having other STIs, persons who request testing for STIs, men having sex with men or heterosexual persons who themselves or whose sex partners have had more than one sex partner since their most recent HIV test. **CDC:** ▪ The CDC recommends annual screening in persons at increased risk but recognizes that clinicians may wish to screen high-risk men who have sex with men more frequently (e.g., every 3-6months) depending on patient's risk factors, local prevalence, and local policies. **PrEP**: ▪ USPSTF recommends that clinicians offer preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition **[A]**: The USPSTF recommends the following persons be considered for PrEP: 1. Sexually active adolescents and adults weighing at least 35 kg (77lb) who have engaged in anal or vaginal sex in the past 6 months and have any of the following: ▪ A sexual partner who has HIV (especially if the partner has an unknown or detectable viral load) ▪ A bacterial STI (syphilis, gonorrhea, or chlamydia for MSM and transgender women; gonorrhea and syphilis for heterosexual women and men) in the past 6 months. ▪ A history of inconsistent/no condom use with sex partner(s) whose HIV status is not known/ who is high risk. 2. Persons who inject drugs and have 1 of the following characteristics: ▪ Shared use of drug injection equipment ▪ Have a drug injecting partner who has HIV. ▪ Have sexual risk for acquiring HIV.
Lung Cancer Screening [51]	**USPSTF:** ▪ Annual screening for lung cancer using low-dose CT scanning in adults aged 50-80 with a 20 pack-year smoking history and who are current smokers or have quit within the past 15 yrs. Screening should be discontinued once a person has not smoked for 15 years, develops a health problem substantially limiting life expectancy, or is unable or unwilling to have curative lung surgery. **[B]** Individuals who currently smoke should receive counseling to quit and be connected to cessation resources. Individuals with comorbid conditions that substantially limit life expectancy should not be screened.

	***ACS Update[99]:** Recommends yearly screening for lung cancer for people aged 50 to 80 years old who smoke or formerly smoked and have a 20-year or greater pack-year history. It eliminates 'years since quitting' requirement.
Obstructive Sleep Apnea[94]	**USPSTF:** ▪ Current evidence is insufficient to assess the balance of benefits & harms of screening for Obstructive Sleep Apnea (OSA). **[I]**
Osteoporosis Screening [52, 53,113]	**USPSTF** ▪Screening for osteoporosis to prevent osteoporotic fractures in all women aged 65 years or older **[B]** and in postmenopausal women younger than 65 years who are at increased risk for osteoporosis, as estimated by clinical risk assessment [B]. ▪Screening most commonly is accomplished by measuring Bone Mineral Density (BMD) with dual-energy x-ray absorptiometry a central site (e.g., total hip, femoral neck, or lumbar spine). ▪USPSTF concludes current evidence is insufficient to assess balance of benefits and harms of screening for osteoporosis to prevent osteoporotic fractures in men. [I]
Ovarian Cancer Screening [54]	USPSTF recommends against screening average risk asymptomatic women for ovarian cancer. **[D];** This recommendation does not apply to women with known genetic mutations that increase their risk for ovarian cancer (e.g., BRCA1/2 mutations); these women need to be referred for genetic counseling and, if indicated, genetic testing.
Pancreatic Cancer[55]	USPSTF recommends against screening for pancreatic cancer in asymptomatic adults **[D]**
Pregnant Persons	▪ Refer to MedStar Perinatal Counseling Guidelines
Prostate Cancer Screening in average and high-risk men and transgender women with a prostate [56-61]	**USPSTF:** ▪ The USPSTF recommends that for men ages 55-69, the decision to screen for prostate cancer be individualized after a discussion of risks and benefits and based on patient preference. **[C]** [57] ▪ USPSTF recommends against PSA-based screening for prostate cancer in men 70 years and older. **[D]** ▪ Decision aids also often ask patients to identify what outcomes are most important to them and can facilitate the discussion. An example of decision aid for prostate cancer screening discussion can be found here: • **Testing for Prostate Cancer Handout** • USPSTF Infographic: **Is Prostate Cancer Screening Right for You?** **American Cancer Society (ACS):** ▪ Age 40-44 y: Engage men at higher risk (≥2 first-degree relatives [father, brothers] with prostate cancer before age 65 y) in shared decision making. ▪ Age 45-49 y: Engage men at high risk (African American race or first-degree relative with prostate cancer before age 65 y) in shared decision making.

	▪ Age ≥50 y with life expectancy >10 y: Engage in shared decision making. ▪ Men who choose to be tested who have a PSA of less than 2.5 ng/ml may only need to be retested every 2 years. Screening (if done) should be done yearly for men whose PSA level is 2.5 ng/ml or higher. **American Urological Association (AUA):** ▪ Age <40 y: Recommend against screening. ▪ Age 40-54 y: Do not recommend routine screening; Screening men at higher risk (African American race or with positive family history): Individualize screening decisions. ▪ Age 55-69 y: Engage men considering PSA-based screening in shared decision making; proceed based on patient values and preferences. If proceeding with screening, consider PSA testing every 2 y or more. ▪ Age ≥70 y or with life expectancy <10-15 y: Do not recommend routine screening. Digital rectal examination (DRE): DRE is not recommended for prostate cancer screening either as an adjunct to prostate-specific antigen (PSA) testing or as a standalone test. However, if a DRE is performed, men with a nodule, induration, or asymmetry on prostate examination should be referred to a urologist, regardless of the PSA result. Family History: Patients for whom there is concern for a hereditary or genetic prostate cancer syndrome may be referred for genetic counseling and possible testing if available.
STI Screening in special populations[89]	**CDC recommendations:** ▪ **CDC-STI screening-recommendations** ▪ **Detection of STI in Special Populations** ▪ **STI-treatment guide mobile app**
Skin Cancer Screening[105]	**USPSTF:** ▪ Current evidence is insufficient to assess the balance of benefits and harms of visual skin examination by a clinician to screen for skin cancer in adolescents and adults [I].
Syphilis Screening [62]	**USPSTF:** ▪ Screening for syphilis is recommended in persons who are at increased risk for infection. **[A]**; Such patients include but may not be limited to men who have sex with men, HIV infected patients, commercial sex workers, young adults, and persons with history of incarceration, military service, diagnosis of another STI, and patients living in areas of high prevalence. A substantial percentage of heterosexual syphilis transmission occurs among persons who use illicit drugs, particularly methamphetamine. ▪ USPSTF recommends early screening for syphilis infection in all pregnant women. [A] (draft update)
Testicular Self-Exam [63]	**USPSTF:** ▪ Testicular cancer screening (by clinicians or by patient self-exam) is not recommended because of the uncommon nature of the condition and the high cure rate when detected. **[D]**

Tuberculosis Screening [64]	**USPSTF:** ▪ Screening for latent tuberculosis should be performed in groups at increased risk. **[B]** ▪ Populations at increased risk for LTBI include patients living in homeless shelters or correctional institutions, patients coming from countries with high prevalence of TB, immunosuppressed patients (persons living with HIV, patients receiving immunosuppressive medications such as chemotherapy or tumor necrosis factor inhibitors, and patients who have received an organ transplant),patients with silicosis, and patients with TB exposure (household contacts or occupational exposure or workers in high risk congregate settings). ▪ Two types of screening tests for LTBI are currently available in the US: the tuberculin skin test (TST) and the interferon-gamma release assay (IGRA) ▪ No evidence on the optimal frequency of screening for LTBI. Reasonable approach is to repeat screening based on specific risk factors; screening frequency could range from 1-time only screening among persons at low risk for future tuberculosis exposure to annual screening among those at continued risk of exposure.
Vaccinations[114]	For complete CDC recommendations for Adult Immunizations consult: **ACIP Adult Immunizations Schedule**
Vitamin D[115]	▪ ***USPSTF (DRAFT in progress 12/17/2024)*** ▪ Recommends against supplementation with vitamin D with or without calcium for the primary prevention of fractures and against supplementation with vitamin D for the prevention of falls in community-dwelling (not living in nursing home/institutional setting) postmenopausal women and men age 60 years or older **[D].** ▪ These recommendations do not apply to persons with diagnosis of osteoporosis, history of osteoporotic fractures, medical conditions associated with vitamin D deficiency or vitamin D malabsorption, or vitamin D deficiency. ▪ It is important that all persons have vitamin D and calcium intake that meets the recommended daily allowance of these nutrients ▪ Evidence is insufficient to assess the balance of benefits and harms of screening for vitamin D deficiency in asymptomatic adults [I]**.**

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