

The following guideline recommends clinical preventive services for adults. The grade definitions used for this guideline are as defined by the United States Preventive Services Task Force (USPSTF).

Grade	Grade Definition
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.
I	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

Recommendation

Health Assessment Screening, History and Counseling	One health maintenance exam (HME) every 1 - 3 years according to risk status, including: Height, weight and Body Mass Index (BMI) [B]; risk evaluation and counseling for obesity (BMI ≥ 30) [B], tobacco use [A], and alcohol use [B]. See individual MQIC guidelines.
Blood Pressure Screening	• Screen for high blood pressure in adults [A]. Screen every two years if BP ≤ 120/80 mm Hg. Annually if BP 120-139/80-89 mm Hg, and more frequently if warranted.
Aspirin Use	• Recommend the use of ASA for men age 45 to 79 years when the potential benefit due to a reduction in MI outweighs the potential harm due to an increase in gastrointestinal hemorrhage [A]. • Recommend the use of ASA for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage [A].
Cholesterol and Lipid Screening	• Measure a fasting lipoprotein profile (i.e. total cholesterol, LDL-C, HDL-C), in men aged 35 years and older [A]. • Measure a fasting lipoprotein profile in women aged 45 years and older if they are at increased risk for CHD (i.e. diabetes, family history cardiovascular disease before age 50 in male relatives or age 60 in female relatives, tobacco use, hypertension, BMI ≥ 30) [A]. • Screen every five years for low risk adults if initial test normal; consider more frequent screening in individuals at increased risk.
Diabetes Mellitus Screening	• Screen for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg [B]. Screen every three years. • In persons with BP ≤ 135/80 mm Hg, screen on an individual basis according to CHD risks and benefits.
Colorectal Cancer Screening for average risk adults	• Screen for colorectal cancer using FOBT, sigmoidoscopy, or colonoscopy, in adults (excluding those with specific inherited syndromes - Lynch syndrome and familial adenomatous polyposis, and IBD) beginning at age 50 years and continuing until age 75 years [A]. Screening intervals assuming 100% adherence to the regimen: Annual FOBT, sigmoidoscopy every 5 years combined with high-sensitivity FOBT every 3 years, or screening colonoscopy every 10 years. The risks and benefits of screening methods vary. • Recommend against routine screening for colorectal cancer in adults age 76 to 85 years [C]. Considerations may support colorectal cancer screening in an individual patient. • Recommend against screening for colorectal cancer in adults older than age 85 years [D].
Osteoporosis Screening with DXA scan	• Screen for osteoporosis in women aged 65 years or older [B]. Optimal screening interval not known. Repeating DXA within eight years does not improve prediction of fractures. • Screen women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors [B]. • The current evidence is insufficient to assess the balance of benefits and harms of screening for osteoporosis in men [I].
Cervical Cancer Screening Pap Smear	• Screen women age 21 to 65 years with cytology every 3 years, or, for women age 30 to 65 years who want to lengthen the screening interval, screen with a combination of cytology and human papillomavirus testing every 5 years [A]. Testing for HPV before age 30 not recommended [D]. • If not high risk, have had adequate screening with normal Pap smears, recommend against screening women older than age 65 [D]. • Routine Pap smear screening not recommended in women who have had a total hysterectomy for benign disease, or age less than 21 [D].
Mammography with or without Clinical Breast Exam (CBE)	• Biennial screening mammography for women aged 50 to 74 years [B]. • The current evidence is insufficient to assess the additional benefits and harms of screening mammography in women 75 years or older [I]. • Recommend against teaching breast self-examination (BSE) [D]. • The current evidence is insufficient to assess the additional benefits and harms of either clinical breast examination (CBE), digital mammography, or MRI, beyond screening mammography in women 40 years or older [I].
Prostate Cancer Screening	• Recommend against routine screening for prostate cancer in men [D].
HIV Screening	• Screen all patients 15 to 65 years of age [A]. Screen all increased risk patients (no age limit) [A] annually.

Immunizations (Consult ACIP website, <http://www.cdc.gov/vaccines/pubs/ACIP-list.htm>, for up-to-date recommendations):

Tdap/Td	After primary series, Td every 10 years. Give Tdap once after age 12.
Varicella	Two doses for persons who lack history of immunization or convincing history of infection.
Zoster	One dose after age 60, unless contraindicated.
Influenza	Annual vaccine.
Pneumococcal vaccine	If risk factors present before age 65. (Dosing intervals depend on risk factors.) One dose for everyone 65 and older. (If a person received a first dose prior to age 65 years, give a single revaccination at age 65, if 5 years or more have elapsed since the first dose.)
HepA, HepB, Meningococcal	If risk factors present.

This guideline lists core management steps. It is based on several sources, including: The Guide to Clinical Preventive Services 2012, Recommendations of the U.S. Preventive Services Task Force (www.preventiveservices.ahrq.gov) and the Advisory Committee on Immunization Practices (ACIP) 2011 Immunization Recommendations (www.cdc.gov). Individual patient considerations and advances in medical science may supersede or modify these recommendations.