Weill Cornell Medicine
Obstetrics & Gynecology

Gynecologic Revisit Form

Please complete this brief history to assist us in providing you with the best care possible.
This form will be added to your medical record.

Date of Visit: _____

Legal Name: _____ Preferred Name: _____

Date of Birth/Age: _____ Preferred Pronoun (i.e. she/he; her/him) _____

Reason for Today's Visit: _____

Sexuality/Gender Identity

What is your sexual orientation?
- ☐ Straight / Heterosexual
- ☐ Lesbian / Gay
- ☐ Bisexual
- ☐ Other_____
- ☐ Decline to state

What sex were you assigned at birth?
- ☐ Female
- ☐ Male
- ☐ Decline to state

What is your gender identity?
- ☐ Female
- ☐ Transgender woman/Transwoman Male
- ☐ Male
- ☐ Transgender man/Transman
- ☐ Gender queer/Gender non-conforming
- ☐ Decline to state

Menstrual History:

Date of last menstrual period: _____

Date of last pap: _____

My period usually occurs every _____days and last for _____days.

Date of last mammogram: _____

Date of last colonoscopy: _____

Date of last bone density: _____

Interval Gynecologic History

Do you have any bleeding between periods? ☐ No ☐ Yes

Do you have pain with your periods? ☐ No ☐ Yes

Are you sexually active? ☐ No ☐ Yes Type of Contraception? _____

Any new sexual partners since your last visit? ☐ No ☐ Yes

Have you ever been tested for HIV? ☐ No ☐ Yes If yes, When? _____

Menopausal symptoms: ☐ Vaginal Dryness ☐ Hot Flashes ☐ Mood Swings ☐ Insomnia ☐ Night Sweats

Interval Medical/Surgical History

Have you had any illnesses or surgeries since your last visit? ☐ No ☐ Yes (If yes, please describe below)

_____

Do you exercise? ☐ No ☐ Yes If yes, how often? _____

Allergies: _____

Current Medications (include vitamins, herbs and other supplements) ***If you receive a medication list, please reconcile meds on that form.*

Name of Medication	Dosage	How often?

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Preferred Name: _____

Date of Birth: _____

Review of Systems- Are you experiencing any of the following symptoms? Please check all that apply.

Constitutional	☐ No	☐ Weight loss	☐ Weight gain	☐ Fever	☐ Fatigue
Eye Problems	☐ No	☐ Vision Changes	☐ Glasses	☐ Contacts	☐ Other
Ear, Nose, Throat	☐ No	☐ Ulcers	☐ Sinusitis	☐ Headache	☐ Hearing Problems
Cardiovascular	☐ No	☐ Chest pain	☐ Leg Swelling	☐ Palpitations	☐ Other
Respiratory	☐ No	☐ Wheezing	☐ Cough	☐ Shortness of Breath	☐ Other
Gastrointestinal	☐ No	☐ Diarrhea	☐ Constipation	☐ Nausea	☐ Vomiting
Urinary	☐ No	☐ Painful Urination	☐ Urgency	☐ Frequency	☐ Bloody Urine
Skin/Breast	☐ No	☐ Breast Pain	☐ Nipple discharge	☐ Breast Mass	☐ Skin Rash
Neurological	☐ No	☐ Fainting	☐ Seizures	☐ Numbness	☐ Trouble Walking
Psychiatric	☐ No	☐ Depression	☐ Anxiety	☐ Other	
Blood/Lymph	☐ No	☐ Easy Bruising	☐ Abnormal Bleeding	☐ Swollen Glands	☐ Other
Musculoskeletal	☐ No	☐ Weakness	☐ Pain	☐ Other	

Any new illnesses in your family? ☐ No ☐ Yes _____

Any big changes? (Job, marriage, new partner, etc.) ☐ No ☐ Yes _____

For Office Use Only:

Clinician Comments:_____ **Reviewed By:** _____