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.

Name: _____

Date Of Birth: _____

Reason for Today's Visit: _____

Menstrual History:

Date of last menstrual period: _____ Date of last mammogram: _____

Date of last pap: _____ Date of last colonoscopy: _____

My period usually occurs every _____ days and last for _____days. 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

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