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Patient Name _____ Date _____

RETURN VISIT INFORMATION UPDATE FORM

Please answer the questions accurately and in detail. It is very important that we are aware of any new developments in your medical status as well as that of your family.

1. What is the reason for your visit today? _____
2. Do you have any specific gynecologic concerns or complaints? _____
3. Has anything changed for you since you were last seen in this office? _____
4. What medications are you currently taking? Please include hormones, including over-the-counter preparations, birth control or any other gynecologic medications. Please list the dosage and how frequently you take your medication.

Medication	Dosage	Frequency	How long have you taken this drug?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. Are you allergic to any medications? _____
6. Have you been diagnosed with any new medical conditions since you were last seen in this office?

7. Have you been hospitalized or had any surgery since your last visit? _____

GYNECOLOGIC PROFILE

8. What was the date of your period, if you have periods? _____
9. What was the date of your last mammogram? _____
10. What was the date of your last bone density DEXA screen? _____
11. What was the date of your last pelvic ultrasound, CT scan or MRI? _____
12. Are you experiencing any abnormal bleeding? _____
13. Are you having pelvic pain? _____
14. Have there been any changes in your personal situation (marriage, divorce, etc.)? _____
15. Are you sexually active? _____ Is your partner: _____ Male -or- _____ Female
16. Have there been any changes in your family medical history (new diagnosis of cancer, blood clotting disorders, etc.)?
