Gynecology Return Visit

Patient Name: ______________________________ HF #: ________________________

Date of Visit: ____________________ DOB: ______________________ Age: _______

Mailing Address: ____

City:_______________________ State: ______________________ Zip: _____________

Preferred Phone#: ____________________ Preferred Pharmacy: _____________________

Date of Last Menstrual Period: ______________________

Reason for Visit: ____

Are you menopausal? ❑Yes ❑No What age did you start? ___________________

Are you taking hormones? ❑Yes ❑No Name of your RX? ___________________

Are you taking birth control? ❑Yes ❑No Name of your RX? ___________________

What is your cycle length? ________ days How often is your cycle? ________ days
Have you had the Gardasil Vaccine? ❑Yes ❑No

What do you do to prevent pregnancy? ____

When and where was your last pap smear performed? ____________________________

Have you ever had an abnormal pap? ❑Yes ❑No

If yes, please indicate the cervical procedures you have had: ______________________

When and where was your last mammogram performed? _________________________

Have you ever had an abnormal mammogram? ❑Yes ❑No

If yes, please indicate the abnormality and procedures done: ______________________

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Have you ever had a colonoscopy? ❑Yes ❑No

Have you ever had an abnormal colonoscopy? ❑Yes ❑No

If yes, please indicate the abnormality found: ________________________________

Have you ever had a Bone Density (DEXA) Scan? ❑Yes ❑No

Are you taking any medications for osteoporosis? ❑Yes ❑No

If Yes, what medications are you taking? _____________________________________

List any new medications that you are taking since your last visit: _________________

____

List any new medical diagnoses since your last visit: ____________________________

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List any new surgeries since your last visit: _____________________________________

____

List any new allergies since your last visit: _____________________________________

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PLEASE MAKE SURE YOU HAVE EMPTIED YOUR BLADDER & LEFT A URINE SAMPLE.

FOR OFFICE USE ONLY :

Age _____ G ____ P ________

Wt __________ Ht ___________

BP ___________ Pulse ______

Order: ____mammogram

____ dexa ____ colonoscopy

____ pap

NOTES:

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