

## McLaren Print System Order

Order No: 55506  
 Order Date: 2020-07-21  
 User: amber jones  
 Phone: 586-286-4880

Ship Location: McLaren Womens Health- Attn; Amber  
 37400 Garfield st 200  
 Clinton Township, mi 48036

### Forms

Quantity: 1000  
 Paragon Dept No: 72100  
 Dept Name: womens health clinton  
 Company Number: 260

Order Total Price: 0.00

Item Number: MM-140-M  
 Item Description: OB/GYN Questionnaire  
 Revision Date: 10/2014  
 Print: 2 sided black and white  
 Paper: 20# White Text  
 Size: 8.5 x 11  
 Fold:  
 Finish:  
 Drill: None  
 Misc Info:

**McLAREN SACCUBS  
OB/GYN QUESTIONNAIRE**

DATE: \_\_\_\_\_ LEGAL NAME: \_\_\_\_\_ MAIDEN NAME: \_\_\_\_\_

**HISTORY**

|  |  |  |   |
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| Pregnancies: <input type="checkbox"/> None <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15 <input type="checkbox"/> 16 <input type="checkbox"/> 17 <input type="checkbox"/> 18 <input type="checkbox"/> 19 <input type="checkbox"/> 20 <input type="checkbox"/> 21 <input type="checkbox"/> 22 <input type="checkbox"/> 23 <input type="checkbox"/> 24 <input type="checkbox"/> 25 <input type="checkbox"/> 26 <input type="checkbox"/> 27 <input type="checkbox"/> 28 <input type="checkbox"/> 29 <input type="checkbox"/> 30 <input type="checkbox"/> 31 <input type="checkbox"/> 32 <input type="checkbox"/> 33 <input type="checkbox"/> 34 <input 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|--|--|--|---|

PERIODS: Age started: \_\_\_\_\_ Age stopped: \_\_\_\_\_  
 Flow is:  Heavy  Medium  Light How many days in a cycle: \_\_\_\_\_ First day of last menstrual period: \_\_\_\_\_  
 Any recent changes in periods:  No  Yes Explain: \_\_\_\_\_

BIRTH CONTROL:  No  Yes Method: \_\_\_\_\_

|   |   |
|---|---|
| Last Mammogram: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal | Last Pap: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
| Any History of Abnormal Pap: <input type="checkbox"/> No <input type="checkbox"/> Yes   |   |

**GENERAL:**  
 Fever  Chills  Sweats  Night sweats  
 Anorexia  Loss of appetite  
 Weight changes  Weight problems

**EYES:**  
 Blurred vision  Double vision  
 Eye pain  Itching  Redness  Swelling

**HEALTHY NERVE, MUSCLE, BONES:**  
 Joint pain  Stiffness  Swelling  
 Muscle weakness  Trembling

**RESPIRATORY:**  
 Shortness of breath  Cough  
 Wheezing  Hoarse voice  
 Frequent respiratory infections

**CARDIOVASCULAR:**  
 High blood pressure  
 Chest pain  Rapid heartbeat  
 Dizziness  Fainting

**NEUROLOGICAL:**  
 Headaches  Dizziness  
 Numbness  Tingling

**PSYCHIATRIC:**  
 Depression  Anxiety  Obsessive-compulsive disorder  
 Bipolar disorder  Schizophrenia

**ENTONTOGENIC:**  
 Alcohol  Tobacco  Marijuana  Cocaine  
 Heroin  Prescription drugs  Over-the-counter drugs

**SKIN AND HAIR:**  
 Acne  Hair loss  Dry skin  
 Warts  Moles  Freckles

**REPRODUCTIVE:**  
 Painful intercourse  Abnormal discharge  
 Menstrual changes  Bleeding between periods

**ALLERGIC/IMMUNOLOGICAL:**  
 Allergies  Asthma  Eczema

**REPRODUCTIVE HEALTH:**  
 Contraception  Fertility  Pregnancy  Miscarriage  Stillbirth  Abortion  Infertility  Menopause

### Spec Info:

**Office Use Only**

Special Learning Needs:  No  Yes, specify: \_\_\_\_\_

Language Preference for Healthcare:  English  Other specify: \_\_\_\_\_

Provider's Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_

OB/GYN QUESTIONNAIRE  
 10/2014 (REV)

Print form  
 See order