

## McLaren Print System Order

Order No: 60672 Reprint Previous Order No: 6260  
 Order Date: 2021-02-26  
 User: MICHELLE GALATI  
 Phone: 5867254604

Ship Location: McLaren Womens Health Chesterfield  
 51086 Fairchild Rd  
 Chesterfield, Michigan 48051

### Forms

Quantity: 100  
 Paragon Dept No: 72000  
 Dept Name: McLaren Womens Health Chesterfield  
 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 BACCOMB  
OB/GYN QUESTIONNAIRE**

DATE \_\_\_\_\_ LEGAL NAME \_\_\_\_\_ MARIEN NAME \_\_\_\_\_

**HISTORY**

Pregnancies _____	Live Births _____	Abortions _____	Miscarriages _____
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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	

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<p><b>GENERAL:</b></p> <p><input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Sweats <input type="checkbox"/> Night sweats  <input type="checkbox"/> Anorexia <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea  <input type="checkbox"/> Constipation <input type="checkbox"/> Loss of appetite  <input type="checkbox"/> Weight changes <input type="checkbox"/> Swelling problems</p> <p><b>EYES:</b></p> <p><input type="checkbox"/> Blurred vision <input type="checkbox"/> Itching  <input type="checkbox"/> Drooping <input type="checkbox"/> Double vision</p> <p><b>HEALTHY NERVE, MUSCLE, BONES:</b></p> <p><input type="checkbox"/> Joint pain (specify) _____  <input type="checkbox"/> Stiffness/aching joints  <input type="checkbox"/> Swelling <input type="checkbox"/> Decreased hearing  <input type="checkbox"/> Headaches <input type="checkbox"/> Frequent nose bleeds  <input type="checkbox"/> Problems with hair/nails <input type="checkbox"/> Osteoporosis</p> <p><b>RESPIRATORY:</b></p> <p><input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough  <input type="checkbox"/> Wheezing <input type="checkbox"/> Blood sputum  <input type="checkbox"/> Congestion/swollen in throat  <input type="checkbox"/> Sore throat <input type="checkbox"/> Pharyngitis</p> <p><b>CARDIOVASCULAR:</b></p> <p><input type="checkbox"/> High blood pressure  <input type="checkbox"/> Chest pain/pressure <input type="checkbox"/> Anginal/heart block  <input type="checkbox"/> Peripheral vascular disease  <input type="checkbox"/> Stroke/TIA  <input type="checkbox"/> Heart failure <input type="checkbox"/> Heart attack  <input type="checkbox"/> Coronary artery disease</p> <p><b>NEUROLOGICAL:</b></p> <p><input type="checkbox"/> Dizziness <input type="checkbox"/> Vertigo  <input type="checkbox"/> Tremor <input type="checkbox"/> Seizures  <input type="checkbox"/> Headaches <input type="checkbox"/> Migraine  <input type="checkbox"/> Memory loss  <input type="checkbox"/> Depression (Check box if any link in the list.)  <input type="checkbox"/> Anxiety (Check box if any link in the list.)  <input type="checkbox"/> Sleep problems</p> <p><b>ENTONTOLOGICAL:</b></p> <p><input type="checkbox"/> Tooth pain  <input type="checkbox"/> Gum disease  <input type="checkbox"/> Mouth sores  <input type="checkbox"/> Dry mouth</p>	<p><b>ENTONTOLOGICAL:</b></p> <p><input type="checkbox"/> Headaches/migraines  <input type="checkbox"/> Dizziness/vertigo  <input type="checkbox"/> Frequent urination <input type="checkbox"/> Frequency  <input type="checkbox"/> Night urination <input type="checkbox"/> Urinary incontinence  <input type="checkbox"/> Urinary tract infection  <input type="checkbox"/> Urinary pain <input type="checkbox"/> Urinary burning  <input type="checkbox"/> Urinary incontinence <input type="checkbox"/> Urinary retention  <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary urgency  <input type="checkbox"/> Urinary hesitancy <input type="checkbox"/> Urinary straining  <input type="checkbox"/> Urinary dribbling <input type="checkbox"/> Urinary leakage  <input type="checkbox"/> Urinary odor <input type="checkbox"/> Urinary color changes  <input type="checkbox"/> Urinary pain <input type="checkbox"/> Urinary burning  <input type="checkbox"/> Urinary incontinence <input type="checkbox"/> Urinary retention  <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary urgency  <input type="checkbox"/> Urinary hesitancy <input type="checkbox"/> Urinary straining  <input type="checkbox"/> Urinary dribbling <input type="checkbox"/> Urinary leakage  <input type="checkbox"/> Urinary odor <input type="checkbox"/> Urinary color changes</p> <p><b>SKIN AND HAIR:</b></p> <p><input type="checkbox"/> Acne <input type="checkbox"/> Eczema  <input type="checkbox"/> Psoriasis <input type="checkbox"/> Dry skin  <input type="checkbox"/> Hair loss <input type="checkbox"/> Hair regrowth  <input type="checkbox"/> Skin rashes <input type="checkbox"/> Skin infections  <input type="checkbox"/> Skin discoloration <input type="checkbox"/> Skin thickening  <input type="checkbox"/> Skin itching <input type="checkbox"/> Skin pain  <input type="checkbox"/> Skin numbness <input type="checkbox"/> Skin tingling  <input type="checkbox"/> Skin burning <input type="checkbox"/> Skin stinging  <input type="checkbox"/> Skin swelling <input type="checkbox"/> Skin redness  <input type="checkbox"/> Skin dryness <input type="checkbox"/> Skin flaking  <input type="checkbox"/> Skin cracking <input type="checkbox"/> Skin bleeding  <input type="checkbox"/> Skin bruising <input type="checkbox"/> Skin lacerations  <input type="checkbox"/> Skin ulcers <input type="checkbox"/> Skin abscesses  <input type="checkbox"/> Skin cysts <input type="checkbox"/> Skin warts  <input type="checkbox"/> Skin moles <input type="checkbox"/> Skin freckles  <input type="checkbox"/> Skin sunburns <input 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<p><input type="checkbox"/> Trouble concentrating on things, such as reading the newspaper or working on a project  <input type="checkbox"/> Poor appetite or "loss of interest"  <input type="checkbox"/> Thoughts that you would be better off dead or thoughts of hurting yourself in some way  <input type="checkbox"/> Feeling or spending too much time on things or activities that you have been having around a lot more than usual?  <input type="checkbox"/> Feeling or spending too much time on things or activities that you have been having around a lot more than usual?  <input type="checkbox"/> Feeling or spending too much time on things or activities that you have been having around a lot more than usual?</p> <p><b>ENTONTOLOGICAL:</b></p> <p><input type="checkbox"/> Trouble concentrating on things, such as reading the newspaper or working on a project  <input type="checkbox"/> Poor appetite or "loss of interest"  <input type="checkbox"/> Thoughts that you would be better off dead or 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**OFFICE USE ONLY**

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

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

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