McLaren Business Products

McLaren Print System Order

Order No: 8446 Reprint Previous Order No: 8367
Order Date: 2015-01-23
User: Jenny Fogelsonger
Phone: 810-342-1725

Ship Location: McLaren Flint Community Medical Center Suite B / Jenny
1314 S. Linden Suite B
Flint, Mi 48532
Forms
Quantity: 500
Paragon Dept No: 63550
Dept Name: McLaren Flint Community Medical Center Suite B
Company Number: 810

Order Total Price: 0.00

Item Number: M-34387
Item Description: Genetic History for Obstetrics Patients
Revision Date: 5/2012
Print: 2 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Misc Info:

McLaren
FLINT
GENETIC HISTORY FOR OBSTETRICS PATIENTS

Name:_____ Today's Date:_____

Birthdate:_____ First Day of Last Menstrual Period:_____

Yes	No	PREVIOUS PREGNANCY Have You . . .	IF YES, PLEASE EXPLAIN
( )	( )	1. Had a stillbirth or more than one miscarriage?	
( )	( )	2. Had less than 1 year since the last birth of child?	
		Have You or the Baby's Father . . .	Baby's Mother / Baby's Father
( )	( )	3. Had any previous children with birth defects, handicaps, or genetic disease?	( ) ( ) / ( ) ( )
( )	( )	4. Had any children who died (other than in accidents)?	( ) ( ) / ( ) ( )
( )	( )	5. Had any premature births?	( ) ( ) / ( ) ( )

YES	NO	CURRENT PREGNANCY Have you . . .	IF YES, PLEASE EXPLAIN
( )	( )	1. Taken any medicine or drug (prescription or non-prescription including herbs, dietary supplements) since becoming pregnant, or since your last period (not including vitamins)?	
( )	( )	2. Had any illness or infection during pregnancy?	
( )	( )	3. Had fever over 101°, or taken saunas or hot whirlpool baths during pregnancy?	
( )	( )	4. Had x-rays or surgery since becoming pregnant?	
( )	( )	5. Been exposed to anesthetic gases, lead, or radiation in your occupation?	
( )	( )	6. Drunk more than one glass of alcohol per week?	
( )	( )	7. Become pregnant while using birth control pills?	
( )	( )	8. Been smoking during the pregnancy?	
( )	( )	9. Had any unusual fatigue?	
( )	( )	10. Had any bladder or kidney infections?	

Yes	No	MEDICAL HISTORY Do You or the Baby's Father . . .	Baby's Mother / Baby's Father	IF YES, PLEASE EXPLAIN
( )	( )	1. Have diabetes?	( ) ( ) / ( ) ( )	
( )	( )	2. Have seizures or epilepsy?	( ) ( ) / ( ) ( )	
( )	( )	3. Have kidney disease?	( ) ( ) / ( ) ( )	
( )	( )	4. Have any medical condition not mentioned?	( ) ( ) / ( ) ( )	
( )	( )	5. Have any birth defects?	( ) ( ) / ( ) ( )	

OVER. . .