

## McLaren Print System Order

Order No: 51086 Reprint Previous Order No: 5567  
 Order Date: 2019-12-17  
 User: Victoria Tijerina  
 Phone: 5173031371

Ship Location: Grand Ledge OB/GYN  
 1035 Charlevoix St  
 Grand Ledge, MI 48837

### Forms

Quantity: 500  
 Paragon Dept No: 51015  
 Dept Name: Grand Ledge OB/GYN  
 Company Number: 810

Order Total Price: 0.00

Item Number: MM-140  
 Item Description: OB/GYN Questionnaire  
 Revision Date: 10/2019  
 Print: 2 sided black and white  
 Paper: 20# White Text  
 Size: 8.5 x 11  
 Fold:  
 Finish:  
 Drill: None  
 Misc Info:

**McLAREN MEDICAL GROUP  
OB/GYN QUESTIONNAIRE**

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

**HISTORY**

Sexual Preference: Male \_\_\_\_\_ Female \_\_\_\_\_ Both \_\_\_\_\_ Prefer Not to Answer \_\_\_\_\_

Pregnancies: _____ <small>(Number)</small>	Live Births: _____ <small>(Number)</small>	Abortions: _____ <small>(Number)</small>	Miscarriages: _____ <small>(Number)</small>
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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: _____ <small>(Date)</small>	Last Pap: _____ <small>(Date)</small>
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

Any History of Abnormal Pap:  No  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"/> Fatigue</p> <p><input type="checkbox"/> Anorexia <input type="checkbox"/> Insomnia <input type="checkbox"/> Irritability <input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Weakness <input type="checkbox"/> Loss of appetite</p> <p><input type="checkbox"/> Weight gain/loss <input type="checkbox"/> Eating problems</p> <p><b>EYES:</b></p> <p><input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision</p> <p><b>EARS, NOSE, THROAT, SINUS:</b></p> <p><input type="checkbox"/> Pain/discomfort (ear)</p> <p><input type="checkbox"/> Congestion/swallowing trouble</p> <p><input type="checkbox"/> Hoarseness <input type="checkbox"/> Decreased hearing</p> <p><input type="checkbox"/> Bad breath <input type="checkbox"/> Frequent nose bleeds</p> <p><input type="checkbox"/> Problems with swallowing <input type="checkbox"/> Swallowing trouble</p> <p><b>RESPIRATORY:</b></p> <p><input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Wheezing <input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Congestion/swallowing trouble</p> <p><input type="checkbox"/> Sore throat <input type="checkbox"/> Strep throat</p> <p><b>CARDIOVASCULAR:</b></p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Heart palpitations <input type="checkbox"/> Rapid heart rate</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Swelling in feet/ankles</p> <p><input type="checkbox"/> Decreased exercise tolerance</p> <p><input type="checkbox"/> Fainting/syncope</p> <p><b>GASTROINTESTINAL:</b></p> <p><input type="checkbox"/> Stomach problems</p> <p><input type="checkbox"/> Indigestion/heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Pain <input type="checkbox"/> Bloating <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea <input type="checkbox"/> Blood in stool</p> <p><input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Pain</p> <p><input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Change in bowel habits</p> <p><input type="checkbox"/> Gastrointestinal disease <input type="checkbox"/> Prostate</p> <p><input type="checkbox"/> Spinal cord</p>	<p><b>OSTEOARTHRAL:</b></p> <p><input type="checkbox"/> Neck/shoulder problems</p> <p><input type="checkbox"/> Painful/limited motion <input type="checkbox"/> Frequency</p> <p><input type="checkbox"/> Night cramps <input type="checkbox"/> Painful in arms</p> <p><input type="checkbox"/> Joint pain <input type="checkbox"/> Joint pain</p> <p><input type="checkbox"/> Joint pain <input type="checkbox"/> Joint pain</p> <p><input type="checkbox"/> Joint pain <input type="checkbox"/> Joint pain</p> <p><input type="checkbox"/> Joint pain <input type="checkbox"/> Joint pain</p> <p><input type="checkbox"/> Joint pain <input type="checkbox"/> Joint pain</p> <p><b>MUSCULOSKELETAL:</b></p> <p><input type="checkbox"/> Muscle aches <input type="checkbox"/> Stiffness (arms)</p> <p><input type="checkbox"/> Swelling <input type="checkbox"/> Joint pain (arms)</p> <p><input type="checkbox"/> Swelling <input type="checkbox"/> Joint pain (arms)</p> <p><input type="checkbox"/> Swelling <input type="checkbox"/> Joint pain (arms)</p> <p><b>MENSTRUATION:</b></p> <p><input type="checkbox"/> Heavy periods</p> <p><input type="checkbox"/> Painful periods</p> <p><input type="checkbox"/> Irregular periods</p> <p><input type="checkbox"/> Heavy periods</p> <p><input type="checkbox"/> Painful periods</p> <p><input type="checkbox"/> Irregular periods</p> <p><b>PSYCHIATRIC:</b></p> <p><input type="checkbox"/> Stress <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Memory loss</p> <p><input type="checkbox"/> Depression (check box if any time in the last 12 months you have experienced any of the following):</p> <p><input type="checkbox"/> Little interest or pleasure in doing things?</p> <p><input type="checkbox"/> Feeling tired or sleeping too much or sleeping too little?</p> <p><input type="checkbox"/> Feeling sad, depressed or hopeless?</p> <p><input type="checkbox"/> Feeling/being about yourself or that you are a failure or have let yourself or your family down?</p> <p><input type="checkbox"/> Feeling tired or having little energy?</p>	<p><input type="checkbox"/> Trouble concentrating on things, such as reading the newspaper or watching television?</p> <p><input type="checkbox"/> Poor appetite or overeating?</p> <p><input type="checkbox"/> Thoughts that you would be better off dead or thoughts of hurting yourself in some way?</p> <p><input type="checkbox"/> Feeling or spending too much time that other people could have noticed? Or the opposite, being so busy or restless that you have been doing around a lot more than usual?</p> <p><b>ENDOCRINE:</b></p> <p><input type="checkbox"/> Thyroid trouble <input type="checkbox"/> Hot or cold intolerance</p> <p><input type="checkbox"/> Excessive sweating <input type="checkbox"/> Hot flashes</p> <p><input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss</p> <p><b>NEUROLOGICAL/NEUROMUSCULAR:</b></p> <p><input type="checkbox"/> Numbness/tingling</p> <p><input type="checkbox"/> Tremor</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Balance problems</p> <p><input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Swallowing trouble</p> <p><b>REPRODUCTIVE HEALTH:</b></p> <p><input type="checkbox"/> Unwanted pregnancy</p> <p><input type="checkbox"/> Family planning advice</p> <p><input type="checkbox"/> Contraception use</p> <p><input type="checkbox"/> History of sexually transmitted disease</p> <p><input type="checkbox"/> Sexual problems</p>
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**OFFICE USE ONLY**

Bold print in medical history may indicate **diets/nutritional assessment**.

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

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

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

Print Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

OB/GYN QUESTIONNAIRE  
MM-140-10/19