

## McLaren Print System Order

Order No: 54909 Reprint Previous Order No: 5567  
 Order Date: 2020-06-22  
 User: Kristal Johnson  
 Phone: 810-487-3601

Ship Location: McLaren Flushing CMC  
 2487 N Elms Rd  
 Flushing, MI 48433

### Forms

Quantity: 100  
 Paragon Dept No: 63600  
 Dept Name: McLaren Flushing CMC  
 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: \_\_\_\_\_ MARDEN NAME: \_\_\_\_\_

**HISTORY**

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

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: _____	Last Pap: _____
_____	_____

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"/> Night sweats <input type="checkbox"/> Weight loss <input type="checkbox"/> Anorexia <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Weight gain <input type="checkbox"/> Swelling <input type="checkbox"/> Fatigue</p> <p><b>EYES:</b></p> <p><input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Pain <input type="checkbox"/> Redness <input type="checkbox"/> Swelling <input type="checkbox"/> Itching <input type="checkbox"/> Dryness</p> <p><b>EAR, NOSE, THROAT, SINUS:</b></p> <p><input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Itching <input type="checkbox"/> Dryness <input type="checkbox"/> Runny nose <input type="checkbox"/> Sore throat <input type="checkbox"/> Hoarseness <input type="checkbox"/> Difficulty swallowing</p> <p><b>RESPIRATORY:</b></p> <p><input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Chest pain <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Frequent respiratory infections <input type="checkbox"/> Persistent cough</p> <p><b>CARDIOVASCULAR:</b></p> <p><input type="checkbox"/> High blood pressure <input type="checkbox"/> Chest pain <input type="checkbox"/> Rapid heart rate <input type="checkbox"/> Irregular heart rate <input type="checkbox"/> Swelling in legs <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Difficulty exercising</p> <p><b>GASTROINTESTINAL:</b></p> <p><input type="checkbox"/> Stomach pain <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in stool <input type="checkbox"/> Blood in vomit <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Pain <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Change in bowel habits <input type="checkbox"/> Gastrointestinal disease <input type="checkbox"/> Prostate <input type="checkbox"/> Testes</p>	<p><b>OSTEOPOROSIS:</b></p> <p><input type="checkbox"/> Bone pain <input type="checkbox"/> Fractures <input type="checkbox"/> Height loss <input type="checkbox"/> Osteoporosis</p> <p><b>MUSCULOSKELETAL:</b></p> <p><input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Stiffness <input type="checkbox"/> Weakness <input type="checkbox"/> Difficulty walking <input type="checkbox"/> Falls</p> <p><b>NEUROLOGICAL:</b></p> <p><input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Tremor <input type="checkbox"/> Seizures <input type="checkbox"/> Memory loss <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Sleep problems <input type="checkbox"/> Personality changes <input type="checkbox"/> Difficulty concentrating</p> <p><b>PSYCHIATRIC:</b></p> <p><input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Sleep problems <input type="checkbox"/> Personality changes <input type="checkbox"/> Difficulty concentrating</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 so much time that other people could have noticed? Or the opposite, being so happy or excited that you have been doing several things that you have never done?</p> <p><b>ENDOCRINE:</b></p> <p><input type="checkbox"/> Thyroid problems <input type="checkbox"/> Diabetes or low tolerance <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Hot flashes <input type="checkbox"/> Night sweats</p> <p><b>HEMATOLOGICAL/IMMUNE:</b></p> <p><input type="checkbox"/> Swollen glands <input type="checkbox"/> Swollen lymph nodes <input type="checkbox"/> Frequent infections <input type="checkbox"/> Easy bruising <input type="checkbox"/> Frequent bleeding <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Swelling <input type="checkbox"/> Dry skin</p> <p><b>REPRODUCTIVE HEALTH:</b></p> <p><input type="checkbox"/> Unwanted pregnancy <input type="checkbox"/> Difficulty conceiving <input type="checkbox"/> Menstrual pain <input type="checkbox"/> Difficulty with sexual intercourse <input type="checkbox"/> Painful sex</p>
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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: \_\_\_\_\_

Print Name: \_\_\_\_\_  
 Date/Time: \_\_\_\_\_

OB/GYN QUESTIONNAIRE  
 10/19/2019