McLaren Business Products

McLaren Print System Order

Order No: 55399 Reprint Previous Order No: 5567
Order Date: 2020-07-15
User: Victoria Tijerina
Phone: 5173031371

Ship Location: Grand Ledge OB/GYN
1035 Charlevoix Dr Ste 200
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: _____ MAIDEN NAME: _____

HISTORY

Sexual Preference: Male _____ Female _____ Both _____ Prefer Not to Answer _____

(Number) Pregnancies:	(Number) Live Births:	(Number) Abortions:	(Number) Miscarriages:

PERIODS: Age started: _____ Age stopped: _____
Flow: is: ☐heavy ☐medium ☐light How many days is a cycle _____ First day of last menstrual period: _____
Any recent changes in periods ☐No ☐Yes Explain: _____

BIRTH CONTROL: ☐No ☐Yes Method: _____

Last Mammogram: _____ (Date) ☐Normal ☐Abnormal Last Pap: _____ (Date) ☐Normal ☐Abnormal
Any History of Abnormal Pap: ☐No ☐Yes

GENERAL:
☐fever ☐chills ☐sweats ☐fatigue
☐sleeplessness ☐headaches ☐dizziness
☐weakness ☐**loss of appetite**
☐**weight loss/gain** ☐**eating problems**

EYES:
☐drainage ☐redness ☐itching
☐burning ☐double vision

EARS, NOSE, THROAT, MOUTH:
☐pain/pressure (ar/sinus) _____
☐congestion/clearing (sinus) _____
☐sneezing ☐decreased hearing
☐bad breath ☐frequent nose bleeds
☐problem with teeth/gums ☐hoarseness

RESPIRATORY:
☐shortness of breath ☐cough
☐wheezing ☐blood sputum
☐congestion/heaviness in chest
☐asthma ☐tuberculosis

CARDIOVASCULAR:
☐high blood pressure
☐chest pain/pressure ☐irregular/rapid beat
☐pain/numbness/arm pain
☐excessive sweating ☐poor coloring
☐swelling/fluid retention ☐rheumatic fever
☐varicose veins/phlebitis

GASTROINTESTINAL:
☐**stomach problems**
☐**indigestion/heartburn** ☐**nausea** ☐**vomiting**
☐**pain** ☐**diarrhea** ☐**constipation**
☐blood in stools ☐blood in vomitus
☐hemorrhoids ☐pain
☐rectal bleeding ☐**change in bowel habits**
☐gallbladder disease ☐hepatitis
☐special diet

GENITOURINARY:
☐kidney/bladder problems
☐burning/painful urination ☐frequency
☐night urination ☐blood in urine
☐genital sores/ ☐urine loss
☐pelvic pain ☐itching ☐bleeding
☐pelvic/ intercourse ☐abnormal periods
☐abnormal pap (history of)

MUSCULOSKELETAL:
☐body ache ☐stiffness (area) _____
☐swelling ☐joint pain (area) _____
☐warmth ☐arthritis/gout

SKIN and/or BREAST:
☐wounds (area) _____
☐sores (area) _____
☐dryness ☐itching ☐rashes
☐discoloration ☐lightening ☐bruise easily
☐perform breast self exam ☐discharge

NEUROLOGICAL:
☐tingling (area) _____
☐numbness ☐paralysis
☐convulsions/seizures

PSYCHIATRIC:
☐stress ☐anxiety ☐agitation ☐memory loss
☐depression (Check box if any time in the last 2 weeks you have experienced any of the following.)
☐Little interest or pleasure in doing things?
☐Trouble falling or staying asleep, or sleeping too much?
☐Feeling down, depressed, or hopeless?
☐Feeling bad about yourself or that you are a failure or have let yourself or your family down?
☐Feeling tired or having little energy?
☐Trouble concentrating on things, such as reading the newspaper or watching television?
☐Poor appetite or overeating?
☐Thoughts that you would be better off dead or thoughts of hurting yourself in some way?
☐Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual?

ENDOCRINE:
☐thyroid trouble ☐heat or cold intolerance
☐excessive sweating ☐thirst
☐hunger ☐**diabetes**

HEMATOLOGIC/LYMPHATIC:
☐swollen glands ☐tenderness of glands ☐**anemia**

ALLERGIC/IMMUNOLOGIC:
☐respiratory distress ☐hives
☐itching
☐difficulty swallowing ☐swelling
☐hay fever

REPRODUCTIVE HEALTH:
☐suspected pregnancy
☐currently sexually active
☐condom use
☐history of sexually transmitted disease
☐sexual problems

OFFICE USE ONLY
Bold print in medical history may indicate dietician/nutritional assessment.
Special Learning Needs: ☐No ☐Yes, specify: _____
Language Preference for Healthcare: ☐English ☐Other specify: _____
Provider's Signature: _____ Date/Time: _____

OB/GYN QUESTIONNAIRE

Patient Name:

Date of Birth: