

## McLaren Print System Order

Order No: 57089 Reprint Previous Order No: 6260  
 Order Date: 2020-09-25  
 User: MICHELLE GALATI  
 Phone: 5867254604

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

### Forms

Quantity: 500  
 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
<input type="checkbox"/> None <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15 <input type="checkbox"/> 16 <input type="checkbox"/> 17 <input type="checkbox"/> 18 <input type="checkbox"/> 19 <input type="checkbox"/> 20 <input type="checkbox"/> 21 <input type="checkbox"/> 22 <input type="checkbox"/> 23 <input type="checkbox"/> 24 <input type="checkbox"/> 25 <input type="checkbox"/> 26 <input type="checkbox"/> 27 <input type="checkbox"/> 28 <input type="checkbox"/> 29 <input type="checkbox"/> 30 <input type="checkbox"/> 31 <input type="checkbox"/> 32 <input type="checkbox"/> 33 <input type="checkbox"/> 34 <input type="checkbox"/> 35 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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
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<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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**GENERAL:**  
 Fever  Chills  Sweats  Night sweats  
 Anorexia  Loss of appetite  
 Weight changes  Weight problems

**EYES:**  
 Blurred vision  Double vision  
 Dry eyes  Itchy eyes

**HEALTHY NERVE, MUSCLE, BONES:**  
 Joint pain  Stiff joints  
 Muscle weakness  Muscle cramps  
 Bone pain  Osteoporosis

**RESPIRATORY:**  
 Shortness of breath  Cough  
 Wheezing  Hoarse voice  
 Frequent respiratory infections

**CARDIOVASCULAR:**  
 High blood pressure  
 Low blood pressure  Heart palpitations  
 Chest pain  Dizziness  
 Fainting  Stroke

**NEUROLOGICAL:**  
 Headaches  Migraine  
 Seizures  Tremor  
 Memory loss

**PSYCHIATRIC:**  
 Depression  Anxiety  Panic attacks  
 Sleep problems  Substance use  
 Self-harm  Thoughts of suicide

**ENTONTOGENIC:**  
 Constipation  Diarrhea  
 Nausea  Vomiting  
 Bloating  Gas

**UROGENITAL:**  
 Urinary tract infection  
 Urinary incontinence  
 Hematuria

**REPRODUCTIVE HEALTH:**  
 Menstrual pain  
 Vaginal dryness  
 Vaginal discharge  
 Pelvic pain

**OTHER:**  
 Allergies  
 Autoimmune disease  
 Cancer  
 Diabetes  
 HIV/AIDS  
 Kidney disease  
 Liver disease  
 Lung disease  
 Thyroid disease  
 Vitamin deficiencies

**OFFICE USE ONLY**

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

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

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

Print form  
See order

OB/GYN QUESTIONNAIRE  
MM-140-M-1014