McLaren Business Products

McLaren Print System Order

Order No: 57845 Reprint Previous Order No: 5567
Order Date: 2020-10-26
User: Victoria Tijerina
Phone: 5173031371

Ship Location: Grand Ledge Health Center
1035 Charlevoix Dr Ste 200
Grand Ledge , MI 48837
Forms
Quantity: 1000
Paragon Dept No: 51015
Dept Name: McLaren Grand Ledge
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 (annies): _____
❑congestion/clearing (annies): _____
❑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
❑gas ❑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 ❑bruises 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: