

McLaren Print System Order

Order No: 59894 Reprint Previous Order No: 5567
 Order Date: 2021-01-27
 User: brandy wakefield
 Phone: 5862864880

Ship Location: McLaren Macomb Womens Health
 1030 Harrington Boulevard Suite 201
 mt clemens, mi 48043

Forms

Quantity: 500
 Paragon Dept No: 52074
 Dept Name: McLaren Macomb Womens Health
 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>
-----------------------------------------------	-----------------------------------------------	---------------------------------------------	------------------------------------------------

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

<p>GENERAL:</p> <p><input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Sweats <input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Irritability <input type="checkbox"/> Irritability <input type="checkbox"/> Irritability</p> <p><input type="checkbox"/> Anorexia <input type="checkbox"/> Loss of appetite</p> <p><input type="checkbox"/> Weight changes <input type="checkbox"/> Eating problems</p> <p>EYES:</p> <p><input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision</p> <p>EAR, NOSE, THROAT, SINUS:</p> <p><input type="checkbox"/> Painful or itchy eyes</p> <p><input type="checkbox"/> Frequent nose bleeds</p> <p>RESPIRATORY:</p> <p><input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Wheezing <input type="checkbox"/> Hoarse voice</p> <p>CARDIOVASCULAR:</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Chest pain</p> <p>NEUROLOGICAL:</p> <p><input type="checkbox"/> Headaches</p> <p>PSYCHIATRIC:</p> <p><input type="checkbox"/> Depression</p>	<p>OSTEOPOROSIS:</p> <p><input type="checkbox"/> Bone pain</p> <p>MUSCULOSKELETAL:</p> <p><input type="checkbox"/> Joint pain</p> <p>RENAL/URINARY:</p> <p><input type="checkbox"/> Urinary problems</p> <p>ENDOCRINE:</p> <p><input type="checkbox"/> Diabetes</p> <p>HEMATOLOGICAL/IMMUNE:</p> <p><input type="checkbox"/> Anemia</p> <p>REPRODUCTIVE HEALTH:</p> <p><input type="checkbox"/> Menstrual problems</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 busy or restless that you have been doing around a lot more than usual?</p> <p>ENDOCRINE:</p> <p><input type="checkbox"/> Thyroid problems (Hot or cold intolerance)</p> <p><input type="checkbox"/> Excessive sweating (Night sweats)</p> <p>HEMATOLOGICAL/IMMUNE:</p> <p><input type="checkbox"/> Frequent infections</p> <p>ALLERGIC/IMMUNOLOGIC:</p> <p><input type="checkbox"/> Allergic reactions</p> <p>REPRODUCTIVE HEALTH:</p> <p><input type="checkbox"/> Unplanned pregnancy</p> <p><input type="checkbox"/> Sexually transmitted infection</p> <p><input type="checkbox"/> History of sexually transmitted infection</p> <p><input type="checkbox"/> Cervical problems</p>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

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
MM-140-10/19