McLaren Business Products

**McLaren Print System Order**

**Order No: 7133**
**Order Date: 2014-11-14**
**User: cindy martin**
**Phone: 517233-0170**

**Ship Location: eaton rapids womens health attn cindy**
**101 e spicervilley hwy**
**eaton rapids, mi 48827**
**Forms**
**Quantity: 500**
**Paragon Dept No: 67425**
**Dept Name: mclaren greater lansing eaton rapids womens health**
**Company Number: 810**

**Order Total Price: 0.00**

**Item Number: MM-140**
**Item Description: OB/GYN Questionnaire**
**Revision Date: 11/2013**
**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

| Pregnancies (Number) | Live Births (Number) | Abortions (Number) | Miscarriages (Number) |
|---|---|---|---|

PERIODS: Age started _____ Age stopped _____
Flow is: ☐ heavy ☐ medium ☐ light How many days is a cycle _____ Date 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
☐ Weight loss/gain ☐ Eating problems

EYES
☐ Blurred vision ☐ Redness ☐ Itching
☐ Watering ☐ Double vision

EARS, NOSE, THROAT, MOUTH
☐ Ear pain/pressure (ears)
☐ Congestion/drainage (sinus)
☐ Hearing ☐ Decreased hearing
☐ Bad breath ☐ Frequent sore throats
☐ Problem with teeth/gums ☐ Hoarseness

RESPIRATORY
☐ Shortness of breath ☐ Cough
☐ Wheezing ☐ Blood spitting
☐ Congestion/tiredness in chest
☐ Asthma ☐ Bronchitis

CARDIOVASCULAR
☐ High blood pressure
☐ Chest pain/pressure ☐ Irregular/rapid beat
☐ Leg/ankle/calf pain
☐ 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 ☐ Vaginal bleeding
☐ Pelvic pain ☐ Itching ☐ Bleeding
☐ Painful intercourse ☐ Abnormal periods
☐ Abnormal pap (history of)

MUSCULOSKELETAL
☐ Body aches ☐ Stiffness (areas)
☐ Swelling ☐ Joint pain (areas)
☐ Muscle ☐ Arthritis (joint)

SKIN (and/or BREAST)
☐ Moles (area) _____
☐ Rashes (area) _____
☐ Bruises ☐ Itching ☐ Hives
☐ Discoloration ☐ Tightening ☐ Breast nodule
☐ Breast/armpit pain ☐ Discharge

NEUROLOGICAL
☐ Weakness (area) _____
☐ Numbness ☐ Paralysis
☐ Convulsions/seizures

PSYCHIATRIC
☐ Stress ☐ Anxiety ☐ Agitation ☐ Insomnia/sleep
☐ Depression (Check here if any time in the last 7 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
☐ Hyperactivity ☐ Heat or cold intolerance
☐ Excessive sweating ☐ Thirst ☐ Hunger ☐ Diabetes

HEMATOLOGIC/LYMPHATIC
☐ Swollen glands ☐ Tenderness of glands ☐ Anemia

ALLERGY/IMMUNOLOGIC
☐ Respiratory distress ☐ Hives ☐ Itching
☐ Difficulty swallowing ☐ Swelling
☐ Body 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