McLaren Business Products

McLaren Print System Order

Order No: 8855 Reprint Previous Order No: 5567
Order Date: 2015-02-09
User: Jenny Fogelsonger
Phone: 810-342-1725

Ship Location: McLaren Flint Community Medical Center Suite B / Jenny
1314 S. Linden Suite B
Flint, Mi 48532
Forms
Quantity: 1000
Paragon Dept No: 63550
Dept Name: McLaren Flint Community Medical Center Suite B
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 ☐ Weight gain ☐ Eating problems

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

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

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

CARDIOVASCULAR
☐ High blood pressure
☐ Chest pain/pressure ☐ Irregular/rapid beat
☐ Leg/ankle/foot 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
☐ Bright urination ☐ Blood in urine
☐ Genital sores ☐ Vaginal pain
☐ Pelvic pain ☐ Itching ☐ Bleeding
☐ Irregular menstrual ☐ 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 ☐ Lightening ☐ Bruises easily
☐ Breast/breast self exam ☐ Discharge

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

PSYCHIATRIC
☐ Stress ☐ Anxiety ☐ Agitation ☐ Insomnia/sleep
☐ Depression (Check this 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

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

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

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