McLAREN MEDICAL GROUP
OB/GYN QUESTIONNAIRE

DATE: _____ LEGAL NAME: _____ MAIDEN NAME: _____

HISTORY

Sexual Preference: Male_____ Female _____ Both _____ Prefer Not to Answer _____

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 _____ 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
❑ blurring ❑ double vision

EARS, NOSE, THROAT, MOUTH:
❑ pain/pressure (areas) _____
❑ congestion/draining (areas) _____
❑ 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
❑ jaw/shoulder/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
❑ painful 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 ❑ tightening ❑ bruise 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: _____

Patient Name:

Date of Birth:

FAMILY HISTORY

Check if you or your family member have had any of the following:

Self	Mother's Family	Father's Family	
			Diabetes
			Heart Trouble/ Murmur
			Stroke or High Blood Pressure
			Asthma, Allergies, Hives, Eczema
			Blood Disease (Anemia, sickle cell, etc.)
			Rheumatism, Arthritis
			Tuberculosis
			Mental Disease, Nervous Breakdown
			Cancer. list type(s) _____
			Gallbladder Disease
			Birth Defects, Hereditary disease
			Migraines or other headaches
			Blood clots (thrombophlebitis, pulmonary embolism)
			High Cholesterol or Triglycerides
			Breast abnormalities
			DES Exposure
			Lung Disease
			Thyroid Disease
			Liver Disease (Hepatitis, Hemochromatosis, Cirrhosis)
			Kidney, Bladder Disease
			Epilepsy/Seizures/Convulsions
			History of Substance Abuse
			Stomach or Intestinal Disease
			Osteoporosis

ADDITIONAL MEDICAL PROBLEMS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES (drugs, latex, foods, etc.)

_____

_____

_____

_____

HOSPITALIZATIONS AND/OR SURGERIES

Date	Diagnosis / Procedure
_____	_____
_____	_____
_____	_____
_____	_____

CURRENT MEDICATIONS (including prescription, over the counter, herbal supplements)

1 _____ 5 _____

2 _____ 6 _____

3 _____ 7 _____

4 _____ 8 _____

SAFETY: 1. Have you fallen in the last year? ❑ YES ❑ NO

2a. Do you feel safe at home? ❑ YES ❑ NO

2b. Has any one ever - Hit you? ❑ YES ❑ NO - Insulted you or put you down? ❑ YES ❑ NO

- Threatened you? ❑ YES ❑ NO - Forced sex upon you? ❑ YES ❑ NO

2c. If you answered "yes" to any part of number 2 would you like help dealing with this situation? ❑ YES ❑ NO

3. Do you keep firearms in the home? ❑ YES ❑ NO

3.a. If you answered "yes" to number 3, do you take safety precations with firearms in the home? ❑ YES ❑ NO

SOCIAL HISTORY

Tobacco use *(smoke or chew):* ❑ yes ❑ no If yes, what?_____ If no, have you in the past ❑ YES ❑ NO

How much?_____ per day x _____ years ❑

Alcohol use: ❑ yes ❑ no If yes, what?_____ How much?_____ per day _____ x per week ❑

Recreational Drugs: ❑ yes ❑ no If yes, what?_____ How much?_____ per day _____ x per week ❑

Caffeine: ❑ yes ❑ no If yes, source _____ amount _____ per day ❑

Exercise: ❑ yes ❑ no If yes, specify type _____ How often? _____ ❑

Occupation:_____ Contact with chemicals, lead, excessive noise or blood / body fluids at work: ❑ yes ❑ no

(circle those applicable)

ADVANCE DIRECTIVES:

Do you have an Advance Directive, i.e., written instructions for your family and health care provider in the event that you cannot make a decision yourself about your care? ☐ Yes ☐ No

Would you like information on Advance Directives? ☐ Yes ☐ No

Info given ☐ (staff use)

_____

Patient's Signature Date

_____

Provider's Signature Date/Time

Patient Name:

Date of Birth: