

McLaren Print System Order

Order No: 69886 Reprint Previous Order No: 5567
 Order Date: 2022-05-16
 User: ashley d'souza
 Phone: 5179751402

Ship Location: MGL Okemos Womens
 2104 jolly Rd ste 220
 Okemos, Mi 48864

Forms

Quantity: 1000
 Paragon Dept No: 67160
 Dept Name: MGL Okemos Womens
 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 _____ **Partner Not to Answer**

Pregnancies: _____	Live Births: _____	Abortions: _____	Miscarriages: _____
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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: _____	Last Pap: _____
_____	_____

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"/> Anemia <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Irritability <input type="checkbox"/> Insomnia <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>EARS, NOSE, THROAT, SINUS:</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 <input type="checkbox"/> Rapid heart rate</p> <p>GI/INTESTINAL:</p> <p><input type="checkbox"/> Stomach problems</p> <p><input type="checkbox"/> Indigestion <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Blood in stool <input type="checkbox"/> Blood in vomit</p> <p><input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Pain</p> <p><input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Change in bowel habits</p> <p><input type="checkbox"/> Gastrointestinal disease <input type="checkbox"/> Prostate</p> <p><input type="checkbox"/> Urinary tract</p>	<p>OSTEOPOROSIS:</p> <p><input type="checkbox"/> Bone pain <input type="checkbox"/> Fractures</p> <p>MUSCULOSKELETAL:</p> <p><input type="checkbox"/> Joint pain <input type="checkbox"/> Stiffness</p> <p><input type="checkbox"/> Swelling <input type="checkbox"/> Pain</p> <p>NEUROLOGICAL:</p> <p><input type="checkbox"/> Dizziness <input type="checkbox"/> Headaches</p> <p>PSYCHIATRIC:</p> <p><input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Suicide thoughts</p> <p><input type="checkbox"/> Memory loss</p> <p><input type="checkbox"/> Trouble falling or staying asleep, or sleeping too much</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 too 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 <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Menstrual problems <input type="checkbox"/> Infertility</p> <p>HEMATOLOGIC/IMMUNE:</p> <p><input type="checkbox"/> Frequent infections</p> <p>ALLERGIC/IMMUNOLOGIC:</p> <p><input type="checkbox"/> Allergies</p> <p>REPRODUCTIVE HEALTH:</p> <p><input type="checkbox"/> Unplanned pregnancy</p> <p><input type="checkbox"/> Sexually transmitted infection</p> <p><input type="checkbox"/> Gonorrhea</p> <p><input type="checkbox"/> History of sexually transmitted disease</p> <p><input type="checkbox"/> Cervical problems</p>
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OFFICE USE ONLY

Special Learning Needs: No Yes, specify: _____

Language Preference for Healthcare: English Other specify: _____

Provider's Signature: _____ Date/Time: _____

OB/GYN QUESTIONNAIRE
MM-140-10/19