McLaren Business Products

McLaren Print System Order

Order No: 69952 Reprint Previous Order No: 5567
Order Date: 2022-05-20
User: MICHELLE GALATI
Phone: 5867254604

Ship Location: McLaren Womens Health Chesterfield
51086 Fairchild Rd
Chesterfield, Michigan 48051

Forms
Quantity: 100
Paragon Dept No: 72000
Dept Name: McLaren Womens Health Chesterfield
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: _____ 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/drainage (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
❑ pain/shoulder/arm pain
❑ excessive sweating ❑ poor coloring
❑ swelling/fluid retention ❑ rheumatic fever
❑ varicose veins/phlebitis

GASTROINTESTINAL:
❑ stomach problems
❑ indigestion/heartburn ❑ nausea ❑ vomiting
❑ pain ❑ 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
❑ pain/ intercourse ❑ abnormal periods
❑ abnormal pap (history of)

MUSCULOSKELETAL:
❑ body aches ❑ 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 3 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:

OB/GYN QUESTIONNAIRE