

## McLaren Print System Order

Order No: 70265 Reprint Previous Order No: 5567  
 Order Date: 2022-06-07  
 User: KIMBERLE WISNIEWSKI  
 Phone: 586-412-5122

Ship Location: WOMANS HEALTH NORTHGROVE  
 44200 GARFILED SUITE 164  
 CLINTON TOWNSHIP, MI 48083

### Forms

Quantity: 1000  
 Paragon Dept No: 56506  
 Dept Name: WOMANS HEALTH NORTH GROVE  
 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 \_\_\_\_\_ **Boys** \_\_\_\_\_ **Prefer 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><b>GENERAL:</b></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><b>EYES:</b></p> <p><input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision</p> <p><b>EAR, NOSE, THROAT/ENT:</b></p> <p><input type="checkbox"/> Frequent nose bleeds</p> <p><b>RESPIRATORY:</b></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><b>CARDIOVASCULAR:</b></p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Chest pain <input type="checkbox"/> Rapid heart rate</p> <p><b>GASTROINTESTINAL:</b></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><b>GENITOURINARY:</b></p> <p><input type="checkbox"/> Urinary tract problems</p> <p><input type="checkbox"/> Frequent urination <input type="checkbox"/> Painful urination</p> <p><input type="checkbox"/> Night urination <input type="checkbox"/> Pain in urine</p> <p><input type="checkbox"/> Urinary incontinence</p> <p><input type="checkbox"/> Urinary tract infections</p> <p><b>MUSCULOSKELETAL:</b></p> <p><input type="checkbox"/> Joint pain <input type="checkbox"/> Stiff joints</p> <p><input type="checkbox"/> Back pain <input type="checkbox"/> Neck pain</p> <p><input type="checkbox"/> Bone pain</p> <p><b>SKIN:</b></p> <p><input type="checkbox"/> Rash <input type="checkbox"/> Itching</p> <p><b>NEUROLOGICAL:</b></p> <p><input type="checkbox"/> Dizziness <input type="checkbox"/> Lightheadedness</p> <p><b>PSYCHIATRIC:</b></p> <p><input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Stress</p> <p><input type="checkbox"/> Memory loss</p> <p><input type="checkbox"/> Trouble sleeping</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 so 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><b>ENDOCRINE:</b></p> <p><input type="checkbox"/> Thyroid problems <input type="checkbox"/> Hot or cold intolerance</p> <p><input type="checkbox"/> Excessive sweating <input type="checkbox"/> Dry skin</p> <p><b>HEMATOLOGIC/IMMUNE:</b></p> <p><input type="checkbox"/> Frequent infections</p> <p><b>ALLERGIC/IMMUNOLOGIC:</b></p> <p><input type="checkbox"/> Allergic reactions</p> <p><b>REPRODUCTIVE HEALTH:</b></p> <p><input type="checkbox"/> Unplanned pregnancy</p> <p><input type="checkbox"/> Difficulty conceiving <input type="checkbox"/> Infertility</p> <p><input type="checkbox"/> History of sexually transmitted disease</p> <p><input type="checkbox"/> Menstrual 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: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_