

McLaren Print System Order

Order No: 71056 Reprint Previous Order No: 5567
 Order Date: 2022-07-08
 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 _____ **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: _____
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

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>EAR, NOSE, THROAT, SINUS:</p> <p><input type="checkbox"/> Frequent nose bleeds</p> <p>HEENT:</p> <p><input type="checkbox"/> Frequent sore throats</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"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Hemorrhoids</p>	<p>OSTEOARTHRAL:</p> <p><input type="checkbox"/> Joint pain <input type="checkbox"/> Stiffness</p> <p><input type="checkbox"/> Back pain <input type="checkbox"/> Neck pain</p> <p><input type="checkbox"/> Pain in arms <input type="checkbox"/> Pain in legs</p> <p><input type="checkbox"/> Pain in hands <input type="checkbox"/> Pain in feet</p> <p>MUSCULOSKELETAL:</p> <p><input type="checkbox"/> Muscle aches <input type="checkbox"/> Stiffness</p> <p><input type="checkbox"/> Pain in joints</p> <p>SKIN:</p> <p><input type="checkbox"/> Rash <input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Dry skin <input type="checkbox"/> Hair loss</p> <p>PSYCHIATRIC:</p> <p><input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Panic attacks</p> <p><input type="checkbox"/> Memory loss</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>ENDOCRINE:</p> <p><input type="checkbox"/> Thyroid problems <input type="checkbox"/> Diabetes or low tolerance</p> <p><input type="checkbox"/> Excessive sweating <input type="checkbox"/> Hot flashes</p> <p>NEUROLOGICAL/PHYSIC:</p> <p><input type="checkbox"/> Tremor <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Headaches</p> <p>REPRODUCTIVE HEALTH:</p> <p><input type="checkbox"/> Unwanted pregnancy</p> <p><input type="checkbox"/> Sexually transmitted infection</p> <p><input type="checkbox"/> History of sexually transmitted infection</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: _____