McLaren Business Products

McLaren Print System Order

Order No: 75079 Reprint Previous Order No: 6260
Order Date: 2023-02-03
User: MICHELLE GALATI
Phone: 5867254604

Ship Location: McLaren Womens Health Chesterfield
51086 Fairchild Rd
Chesterfield, Michigan 48051
Forms
Quantity: 500
Paragon Dept No: 72000
Dept Name: McLaren Womens Health Chesterfield
Company Number: 260

Order Total Price: 0.00

Item Number: MM-140-M
Item Description: OB/GYN Questionnaire
Revision Date: 10/2014
Print: 2 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Misc Info:

McLAREN MACOMB
OB/GYN QUESTIONNAIRE

DATE: _____ LEGAL NAME: _____ MAIDEN NAME: _____

HISTORY

Pregnancies:	Live Births:	Abortions:	Miscarriages:

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:
❑blurriness ❑redness ❑itching
❑burning ❑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
❑pain in/under/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 vomit
❑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 (areas)
_____
❑ 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/IMMUNOLOGIC:
❑ 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: _____

OB/GYN QUESTIONNAIRE
Patient Name
Date of Birth