

## McLaren Print System Order

Order No: 78928 Reprint Previous Order No: 6260  
 Order Date: 2023-08-21  
 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: 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 SACCOMB  
OB/GYN QUESTIONNAIRE**

DATE \_\_\_\_\_ LEGAL NAME \_\_\_\_\_ MARIEN NAME \_\_\_\_\_

**HISTORY**

Pregnancies	Live Births	Abortions	Miscarriages
_____	_____	_____	_____

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: <input type="checkbox"/> No <input type="checkbox"/> Yes	

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<p><b>GENERAL:</b></p> <p><input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Sweats <input type="checkbox"/> Night sweats  <input type="checkbox"/> Anorexia <input type="checkbox"/> Weight loss <input type="checkbox"/> Fatigue  <input type="checkbox"/> Anemia <input type="checkbox"/> Loss of appetite  <input type="checkbox"/> Weight changes <input type="checkbox"/> Swelling problems</p> <p><b>EYES:</b></p> <p><input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision  <input type="checkbox"/> Dry eyes <input type="checkbox"/> Itchy eyes</p> <p><b>HEALTHY NERVE, MUSCLE, BONES:</b></p> <p><input type="checkbox"/> Joint pain <input type="checkbox"/> Stiff joints  <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Muscle cramps  <input type="checkbox"/> Bone pain <input type="checkbox"/> Bone density changes</p> <p><b>RESPIRATORY:</b></p> <p><input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough  <input type="checkbox"/> Wheezing <input type="checkbox"/> Hoarse voice  <input type="checkbox"/> Frequent respiratory infections  <input type="checkbox"/> Sinusitis <input type="checkbox"/> Allergies</p> <p><b>CARDIOVASCULAR:</b></p> <p><input type="checkbox"/> High blood pressure  <input type="checkbox"/> Heart disease <input type="checkbox"/> Chest pain  <input type="checkbox"/> Stroke <input type="checkbox"/> Blood clots  <input type="checkbox"/> Anemia <input type="checkbox"/> Blood transfusion</p> <p><b>NEUROLOGICAL:</b></p> <p><input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness  <input type="checkbox"/> Tremors <input type="checkbox"/> Seizures  <input type="checkbox"/> Memory loss <input type="checkbox"/> Depression</p> <p><b>GI/STOMACH/INTESTINAL:</b></p> <p><input type="checkbox"/> Stomach problems <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting  <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea  <input type="checkbox"/> Acid reflux <input type="checkbox"/> Heartburn  <input type="checkbox"/> Irritable bowel syndrome <input type="checkbox"/> Crohn's disease  <input type="checkbox"/> Celiac disease <input type="checkbox"/> Food allergies</p>	<p><b>ENT/NOSE/THROAT:</b></p> <p><input type="checkbox"/> Frequent sinus infections  <input type="checkbox"/> Frequent ear infections  <input type="checkbox"/> Frequent sore throats  <input type="checkbox"/> Frequent tonsillitis  <input type="checkbox"/> Frequent laryngitis  <input type="checkbox"/> Frequent voice changes  <input type="checkbox"/> Frequent hearing problems  <input type="checkbox"/> Frequent ear pain  <input type="checkbox"/> Frequent nosebleeds  <input type="checkbox"/> Frequent dry mouth  <input type="checkbox"/> Frequent dry eyes</p> <p><b>SKIN AND HAIR:</b></p> <p><input type="checkbox"/> Frequent skin rashes  <input type="checkbox"/> Frequent hair loss  <input type="checkbox"/> Frequent nail problems  <input type="checkbox"/> Frequent acne  <input type="checkbox"/> Frequent dry skin  <input type="checkbox"/> Frequent itching  <input type="checkbox"/> Frequent bruising  <input type="checkbox"/> Frequent bleeding  <input type="checkbox"/> Frequent infections</p> <p><b>UROLOGICAL:</b></p> <p><input type="checkbox"/> Frequent urinary tract infections  <input type="checkbox"/> Frequent urinary incontinence  <input type="checkbox"/> Frequent urinary retention  <input type="checkbox"/> Frequent urinary pain  <input type="checkbox"/> Frequent urinary frequency  <input type="checkbox"/> Frequent urinary urgency</p> <p><b>REPRODUCTIVE:</b></p> <p><input type="checkbox"/> Frequent menstrual problems  <input type="checkbox"/> Frequent vaginal dryness  <input type="checkbox"/> Frequent vaginal infections  <input type="checkbox"/> Frequent vaginal pain  <input type="checkbox"/> Frequent vaginal discharge  <input type="checkbox"/> Frequent vaginal bleeding  <input type="checkbox"/> Frequent vaginal odor  <input type="checkbox"/> Frequent vaginal itching  <input type="checkbox"/> Frequent vaginal burning  <input type="checkbox"/> Frequent vaginal numbness  <input type="checkbox"/> Frequent vaginal soreness  <input type="checkbox"/> Frequent vaginal tenderness  <input type="checkbox"/> Frequent vaginal swelling  <input type="checkbox"/> Frequent vaginal bruising  <input type="checkbox"/> Frequent vaginal lacerations  <input type="checkbox"/> Frequent vaginal tears  <input type="checkbox"/> Frequent vaginal ulcers  <input type="checkbox"/> Frequent vaginal warts  <input type="checkbox"/> Frequent vaginal cysts  <input type="checkbox"/> Frequent vaginal abscesses  <input type="checkbox"/> Frequent vaginal fistulas  <input type="checkbox"/> Frequent vaginal prolapse  <input type="checkbox"/> Frequent vaginal hernia  <input type="checkbox"/> Frequent vaginal cancer</p>	<p><b>TRAUMA/ACCIDENTS:</b></p> <p><input type="checkbox"/> History of trauma/accidents  <input type="checkbox"/> History of surgery  <input type="checkbox"/> History of hospitalization  <input type="checkbox"/> History of long-term illness  <input type="checkbox"/> History of chronic pain  <input type="checkbox"/> History of substance use  <input type="checkbox"/> History of mental health issues  <input type="checkbox"/> History of self-harm  <input type="checkbox"/> History of suicidal thoughts  <input type="checkbox"/> History of suicide attempts  <input type="checkbox"/> History of completed suicide</p> <p><b>PSYCHOLOGICAL:</b></p> <p><input type="checkbox"/> History of depression  <input type="checkbox"/> History of anxiety  <input type="checkbox"/> History of bipolar disorder  <input type="checkbox"/> History of schizophrenia  <input type="checkbox"/> History of personality disorder  <input type="checkbox"/> History of eating disorder  <input type="checkbox"/> History of obsessive-compulsive disorder  <input type="checkbox"/> History of post-traumatic stress disorder  <input type="checkbox"/> History of panic disorder  <input type="checkbox"/> History of phobias  <input type="checkbox"/> History of compulsive disorder  <input type="checkbox"/> History of tic disorder  <input type="checkbox"/> History of Tourette syndrome  <input type="checkbox"/> History of attention deficit hyperactivity disorder  <input type="checkbox"/> History of conduct disorder  <input type="checkbox"/> History of oppositional defiant disorder  <input type="checkbox"/> History of intermittent explosive disorder  <input type="checkbox"/> History of antisocial personality disorder  <input type="checkbox"/> History of narcissistic personality disorder  <input type="checkbox"/> History of borderline personality disorder  <input type="checkbox"/> History of avoidant personality disorder  <input type="checkbox"/> History of dependent personality disorder  <input type="checkbox"/> History of obsessive-compulsive personality disorder  <input type="checkbox"/> History of schizoid personality disorder  <input type="checkbox"/> History of schizotypal personality disorder</p> <p><b>ALLERGIES/INTOLERANCES:</b></p> <p><input type="checkbox"/> Food allergies  <input type="checkbox"/> Medication allergies  <input type="checkbox"/> Environmental allergies  <input type="checkbox"/> Latex allergies  <input type="checkbox"/> Anesthesia allergies  <input type="checkbox"/> Blood product allergies  <input type="checkbox"/> Contrast dye allergies  <input type="checkbox"/> Shellfish allergies  <input type="checkbox"/> Peanut allergies  <input type="checkbox"/> Tree nut allergies  <input type="checkbox"/> Soy allergies  <input type="checkbox"/> Wheat allergies  <input type="checkbox"/> Milk allergies  <input type="checkbox"/> Egg allergies  <input type="checkbox"/> Sesame allergies  <input type="checkbox"/> Mustard allergies  <input type="checkbox"/> Sesame allergies  <input type="checkbox"/> Sesame allergies  <input type="checkbox"/> Sesame allergies</p> <p><b>REPRODUCTION/HEALTH:</b></p> <p><input type="checkbox"/> History of infertility  <input type="checkbox"/> History of miscarriage  <input type="checkbox"/> History of stillbirth  <input type="checkbox"/> History of ectopic pregnancy  <input type="checkbox"/> History of gestational diabetes  <input type="checkbox"/> History of preeclampsia  <input type="checkbox"/> History of placental abruption  <input type="checkbox"/> History of placental previa  <input type="checkbox"/> History of postpartum hemorrhage  <input type="checkbox"/> History of postpartum depression  <input type="checkbox"/> History of postpartum anxiety  <input type="checkbox"/> History of postpartum thyroiditis  <input type="checkbox"/> History of postpartum psychosis  <input type="checkbox"/> History of postpartum delirium  <input type="checkbox"/> History of postpartum seizures  <input type="checkbox"/> History of postpartum stroke  <input type="checkbox"/> History of postpartum infection  <input type="checkbox"/> History of postpartum wound healing problems  <input type="checkbox"/> History of postpartum breast problems  <input type="checkbox"/> History of postpartum pelvic floor dysfunction  <input type="checkbox"/> History of postpartum urinary incontinence  <input type="checkbox"/> History of postpartum sexual dysfunction  <input type="checkbox"/> History of postpartum sexual pain  <input type="checkbox"/> History of postpartum sexual satisfaction  <input type="checkbox"/> History of postpartum sexual desire  <input type="checkbox"/> History of postpartum sexual interest  <input type="checkbox"/> History of postpartum sexual arousal  <input type="checkbox"/> History of postpartum sexual orgasm  <input type="checkbox"/> History of postpartum sexual pleasure  <input type="checkbox"/> History of postpartum sexual satisfaction</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-M-1014