McLaren Business Products

McLaren Print System Order

Order No: 84618 Reprint Previous Order No: 5567
Order Date: 2024-04-16
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: 4.48

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/clearing (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/numbness/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 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
☐ pelvic / intercourse ☐ abnormal periods
☐ abnormal pap (history of)

MUSCULOSKELETAL:
☐ body ache ☐ stiffness (area)
_____
☐ swelling ☐ joint pain (area)
_____
☐ warmth ☐ arthritis/gout

SKIN and/or BREAST:
☐ wounds (area) _____
☐ sores (area) _____
☐ dryness ☐ itching ☐ rashes
☐ discoloration ☐ lightening ☐ 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/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: _____

OB/GYN QUESTIONNAIRE
Patient Name
Date of Birth