McLaren Business Products

McLaren Print System Order

Order No: 85082
Order Date: 2024-04-30
Order Request Date:
User: Casey Coleman
Phone: 5862864880

Ship Location: MACOMB WOMENS HEALTH CLINTON
37399 GARFIELD RD SUITE 203
CLINTON TOWNSHIP, MI 48036
Brochures
Quantity: 1000
Paragon Dept No: 52053
Dept Name: WHA CLINTON
Company Number:

Order Total Price: 41.00

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
Poster:
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: 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/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/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
vaginal pain itching bleeding
pain/discomfort during 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): _____
bumps (area): _____
dryness itching rashes
discoloration lightening bruises 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
Frey 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

Spec Info: