

McLaren Print System Order

Order No: 86894
 Order Date: 2024-07-12
 Order Request Date:
 User: Christina Wrinkle
 Phone: 8103421745

Ship Location: McLaren Flint Breast Care
 1314 S. Linden Road, Ste A
 Flint, Michigan 48532

Brochures
 Quantity: 5000
 Paragon Dept No: 50028
 Dept Name:
 Company Number:

Order Total Price: 199.00

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: _____ MARRIED NAME: _____

HISTORY

Sexual Preference: Male _____ Female _____ Both _____ Prefer Not to Answer _____

Pregnancies: None Live Births: None Abortions: None Miscarriages: None

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: None Normal Abnormal Last Pap: None Normal Abnormal
 Any History of Abnormal Pap: No Yes

<p>GENERAL:</p> <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Sweats <input type="checkbox"/> Fatigue <input type="checkbox"/> Anorexia <input type="checkbox"/> Irritability <input type="checkbox"/> Nervousness <input type="checkbox"/> Anemia <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Weight loss/gain <input type="checkbox"/> Eating problems <p>EYES:</p> <input type="checkbox"/> Blurred vision <input type="checkbox"/> Itching <input type="checkbox"/> Burning <input type="checkbox"/> Double vision <p>EARS, NOSE, THROAT, MOUTH:</p> <input type="checkbox"/> Frequent sore throat <input type="checkbox"/> Congestive/chronic sinusitis <input type="checkbox"/> Hoarseness <input type="checkbox"/> Decreased hearing <input type="checkbox"/> Headaches <input type="checkbox"/> Frequent nose bleeds <input type="checkbox"/> Difficulty with dentures <input type="checkbox"/> Toothaches <p>RESPIRATORY:</p> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Hoarse breath <input type="checkbox"/> Congestive/chronic sinusitis in chest <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <p>CARDIOVASCULAR:</p> <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart palpitations <input type="checkbox"/> Angina/heart pain <input type="checkbox"/> Peripheral vascular disease <input type="checkbox"/> Arteriosclerosis <input type="checkbox"/> Poor circulation <input type="checkbox"/> Swelling/leg retention <input type="checkbox"/> Heart rate faster <input type="checkbox"/> Varicose veins/ulcers <p>GASTROINTESTINAL:</p> <input type="checkbox"/> Stomach problems <input type="checkbox"/> Indigestion/heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in stools <input type="checkbox"/> Blood in vomit <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hemip <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Change in bowel habits <input type="checkbox"/> Gastrointestinal disease <input type="checkbox"/> Prostate <input type="checkbox"/> Cancer test	<p>NEUROLOGICAL:</p> <input type="checkbox"/> Dizziness/vertigo/imbalance <input type="checkbox"/> Neurological condition <input type="checkbox"/> Tremor <input type="checkbox"/> Night cramps <input type="checkbox"/> Stiffness in joints <input type="checkbox"/> Joint aches <input type="checkbox"/> Joint pain <input type="checkbox"/> Carpal tunnel <input type="checkbox"/> Tingling <input type="checkbox"/> Numbness <input type="checkbox"/> Memory loss <input type="checkbox"/> Headaches/migraines <input type="checkbox"/> Abnormal periods <input type="checkbox"/> Abnormal pap (other than) <input type="checkbox"/> Headaches <input type="checkbox"/> Stiffness (joints) <input type="checkbox"/> Dizziness <input type="checkbox"/> Joint pain (joints) <input type="checkbox"/> Swelling <input type="checkbox"/> Joint pain (joints) <p>MUSCULOSKELETAL:</p> <input type="checkbox"/> Swelling <input type="checkbox"/> Joint pain (joints) <input type="checkbox"/> Stiffness <input type="checkbox"/> Painful joints <input type="checkbox"/> Muscle aches <input type="checkbox"/> Stiffness (joints) <input type="checkbox"/> Swelling <input type="checkbox"/> Joint pain (joints) <p>SKIN/HAIR/BEARD:</p> <input type="checkbox"/> Hair loss <input type="checkbox"/> Alopecia <input type="checkbox"/> Dry skin <input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Acne <input type="checkbox"/> Ingrown hairs <input type="checkbox"/> Warts/moles <input type="checkbox"/> Skin tags <input type="checkbox"/> Changes in skin color <input type="checkbox"/> Discharge <p>HEALTHY/UNHEALTHY:</p> <input type="checkbox"/> Healthy <input type="checkbox"/> Unhealthy <input type="checkbox"/> Healthy <input type="checkbox"/> Unhealthy <input type="checkbox"/> Healthy <input type="checkbox"/> Unhealthy <input type="checkbox"/> Healthy <input type="checkbox"/> Unhealthy	<p><input type="checkbox"/> Trouble concentrating or things such as reading, the newspaper or watching television? <input type="checkbox"/> Poor appetite or overeating? <input type="checkbox"/> Thoughts that you would be better off dead or thoughts of hurting yourself in some way? <input type="checkbox"/> Worried or spending so much time that other people would have noticed? Or the opposite, being so happy or excited that you have been moving around a lot more than usual?</p> <p>ENDOCRINE:</p> <input type="checkbox"/> Thyroid trouble <input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Weight changes <input type="checkbox"/> Hunger <input type="checkbox"/> Diabetes <p>RENAL/URINARY/GENITAL:</p> <input type="checkbox"/> Urinary problems <input type="checkbox"/> Urinary tract infections <input type="checkbox"/> Urinary incontinence <input type="checkbox"/> Urinary retention <p>ALLERGIC/IMMUNOLOGIC:</p> <input type="checkbox"/> Allergic reactions <input type="checkbox"/> Frequent infections <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Swelling <input type="checkbox"/> Frequent sinusitis <p>REPRODUCTIVE HEALTH:</p> <input type="checkbox"/> Unprotected pregnancies <input type="checkbox"/> Contraception methods <input type="checkbox"/> History of sexually transmitted disease <input type="checkbox"/> Gynecological problems
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OFFICE USE ONLY

Bold print in medical history may indicate deficient/nutritional assessment.

Special Learning Needs: No Yes, specify: _____

Language Preference for Healthcare: English Other specify: _____

Provider's Signature: _____ Date/Time: _____

Spec Info: