

McLaren Print System Order

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 1035 Charlevoix Dr Ste 200
 Grand Ledge, MI 48837

Form
 Quantity: 2500
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 Dept Name: McLaren Grand Ledge
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Order Total Price: 100.50

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 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: (Date) _____ Normal Abnormal Last Pap: (Date) _____ Normal Abnormal
 Any History of Abnormal Pap: No Yes

GENERAL:
 Fear Ankle Swollen Fatigue
 Sleeplessness Headaches Dizziness
 Swelling Loss of appetite
 Weight loss/gain Aching problems

EYES:
 Blurred vision Itching
 Blurred vision

EARS, NOSE, THROAT, MOUTH:
 Ear pain (one or both)
 Ringing in ears
 Hoarseness
 Sore throat
 Difficulty swallowing

RESPIRATORY:
 Shortness of breath Cough
 Wheezing Chest pain
 Frequent colds/flu
 Chest pain with exertion

NEUROLOGICAL:
 Headaches
 Dizziness
 Tremor
 Stiff neck
 Numbness/tingling
 Weakness

PSYCHIATRIC:
 Depression
 Anxiety
 Panic attacks
 Memory loss
 Difficulty concentrating

ENDOCRINE:
 Diabetes
 Thyroid problems
 Osteoporosis
 Gout

HEMATOLOGICAL/IMMUNOLOGICAL:
 Anemia
 Blood clots
 Autoimmune disease

ALLERGIC/IMMUNOLOGICAL:
 Allergies
 Asthma
 Eczema
 Food allergies

REPRODUCTIVE HEALTH:
 Menstrual problems
 Painful intercourse
 Infertility
 History of sexually transmitted disease

OFFICE USE ONLY:
 Special Learning Needs: No Yes, specify: _____
 Language Preference for Healthcare: English Other specify: _____
 Provider's Signature: _____ Date/Time: _____

OB/GYN QUESTIONNAIRE
 8/10/19 (1/1)

Page Name: _____
 Date of Birth: _____