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/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
☐ jaw/shoulder/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
☐ painful 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 ☐ tightening ☐ 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: _____

Patient Name:

Date of Birth:

FAMILY HISTORY

Check if you or your family member have had any of the following:

Self	Mother's Family	Father's Family	
☐	☐	☐	Diabetes
☐	☐	☐	Heart Trouble/ Murmur
☐	☐	☐	Stroke or High Blood Pressure
☐	☐	☐	Asthma, Allergies, Hives, Eczema
☐	☐	☐	Blood Disease (Anemia, sickle cell, etc.)
☐	☐	☐	Rheumatism, Arthritis
☐	☐	☐	Tuberculosis
☐	☐	☐	Mental Disease, Nervous Breakdown
☐	☐	☐	Cancer. list type(s) _____
☐	☐	☐	Gallbladder Disease
☐	☐	☐	Birth Defects, Hereditary disease
☐	☐	☐	Migraines or other headaches
☐	☐	☐	Blood clots (thrombophlebitis, pulmonary embolism)
☐	☐	☐	High Cholesterol or Triglycerides
☐	☐	☐	Breast abnormalities
☐	☐	☐	DES Exposure
☐	☐	☐	Lung Disease
☐	☐	☐	Thyroid Disease
☐	☐	☐	Liver Disease (Hepatitis, Hemochromatosis, Cirrhosis)
☐	☐	☐	Kidney, Bladder Disease
☐	☐	☐	Epilepsy/Seizures/Convulsions
☐	☐	☐	History of Substance Abuse
☐	☐	☐	Stomach or Intestinal Disease
☐	☐	☐	Osteoporosis

ADDITIONAL MEDICAL PROBLEMS:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES (drugs, latex, foods, etc.)

_____
_____
_____
_____

HOSPITALIZATIONS AND/OR SURGERIES

Date	Diagnosis / Procedure
_____	_____
_____	_____
_____	_____
_____	_____

CURRENT MEDICATIONS (including prescription, over the counter, herbal supplements)

1 _____ 5 _____
2 _____ 6 _____
3 _____ 7 _____
4 _____ 8 _____

SAFETY: 1. Have you fallen in the last year? ☐ YES ☐ NO
2a. Do you feel safe at home? ☐ YES ☐ NO
2b. Has any one ever - Hit you? ☐ YES ☐ NO - Insulted you or put you down? ☐ YES ☐ NO
- Threatened you? ☐ YES ☐ NO - Forced sex upon you? ☐ YES ☐ NO
2c. If you answered "yes" to any part of number 2 would you like help dealing with this situation? ☐ YES ☐ NO
3. Do you keep firearms in the home? ☐ YES ☐ NO
3.a. If you answered "yes" to number 3, do you take safety precations with firearms in the home? ☐ YES ☐ NO

SOCIAL HISTORY

Tobacco use *(smoke or chew):* ☐ yes ☐ no If yes, what?_____ If no, have you in the past ☐ YES ☐ NO
How much?_____ per day x _____ years ☐
Alcohol use: ☐ yes ☐ no If yes, what?_____ How much?_____ per day _____ x per week ☐
Recreational Drugs: ☐ yes ☐ no If yes, what?_____ How much?_____ per day _____ x per week ☐
Caffeine: ☐ yes ☐ no If yes, source _____ amount _____ per day ☐
Exercise: ☐ yes ☐ no If yes, specify type _____ How often? _____ ☐
Occupation:_____ Contact with chemicals, lead, excessive noise or blood / body fluids at work: ☐ yes ☐ no
(circle those applicable)

ADVANCE DIRECTIVES: Do you have an Advance Directive, i.e., written instructions for your family and health care provider in the event that you cannot make a decision yourself about your care? ☐ Yes ☐ No
Would you like information on Advance Directives? ☐ Yes ☐ No
Info given ☐ (staff use)

_____
Patient's Signature Date

_____
Provider's Signature Date/Time

Patient Name:

Date of Birth: