Medical History Form

Instructor	Margaret Allen
Class/Level	Adult Learners Level: Beginning-Low Intermediate
Time	60 minutes
Topic	Filling out a medical history form is important in various settings, whether when participating in organized sports team, for employment records, or seeking urgent care or other medical services.
Skill(s) in Focus	Filling out a medical history form for doctor appointments
Goal(s)	Students will list the different components and information needed to fill out a medical history form. Students will be able to verbalize vocabulary and their corresponding meaning about different ailments, injuries, surgeries, medications, allergies, immunizations. Students will be able to read and fill out medical form used at physician's office.

Objectives	By the end of the lesson students will be able to: 1. verbalize the components of a medical history form 2. define vocabulary words describing body parts, medical ailments, surgeries, and injuries. 3. read and fill out medical form when needing services at a physician's office
Materials	Handouts: Medical history form: https://www.uncpn.com/app/files/public/664e1f36-c9bf-4f5f-a03d-93f7ced2b564/uncpn-form-new-patient-medical-history.pdf Ventures student book

Class Description

Warmup Seeking medical care (Time 15 minutes)
Participation: Pairs/Entire class
Objective 1

The teacher will ask students what are the reasons that you would make a doctor appointment or need to go to emergency room. The teacher will write questions on chalkboard, "have you ever been sick, had a broken bone, had the flu, had food poisoning, been to emergency room, been to doctor's appointment in US". If students answer yes, ask them to describe what happened with each of these instances. Ask if they or a family member had to fill out a medical history form in those situations. Hand out to the entire class a copy of an authentic medical history form. What is needed to fill out this form? First is a statement of chief complaint, which is the reason for visit to ER or doctor's office. In addition, the other different sections of the form include personal information, previous surgeries, injuries or ailments, current medications, allergies, immunizations, pregnancies, use of recreational drugs, tobacco, alcohol, regular exercise. Allow opportunity for students to ask questions about meaning of vocabulary words on medical history form.

2. Reading/listening activity (Time: 10 minutes)
Participants: whole class and individual
Objective 2

The teacher calls on student to read aloud a paragraph out about a woman taking her children to the doctor's office. In the paragraph there are several vocabulary words about ailments and physical complaints. After reading the paragraph, students answers yes or no questions individually about the reading passage. The teacher reviews the answers calling on students to read each sentence and give their answer.

3. Writing vocabulary words (Time: 10 minutes)
Participants: Individuals
Objective 2

In this exercise students will look at picture dictionary in Ventures textbook. Students individually match part of body vocabulary with arrow pointing to body part on illustrated picture. Teacher reviews answers as whole class, prompting students with correct answers. Using list of body parts give definition of associated ailments.

Body Part	associated ailments/injuries
Head	Stroke, migraines
Chest	CHF, MI, COPD, asthma, hypertension
Abdomen	Stomach ulcer, hepatitis, urinary tract infections, renal failure, diabetes
Legs/arms	Arthritis, fracture, blood clots

4. Grammar use of simple present of have (Time: 5-10 minutes)
Participants: Individual
Objective 2

The teacher reviews the conjugation of simple present of verb to have (a cold, headache, a stomachache, etc.) The students practice using simple present tense of verb to have by filling in blank to complete sentences about ailments/complaints. Students take turns and read aloud the completed sentences. Then the teacher prompts students to make any needed corrections.

5. Reading/Writing (Time: 15 minutes)
Participants: whole class and in pairs
Objective 3

Students are given a blank medical history form that patents will fill out when seeking services from a medical professional. The teacher asks students what reasons somebody could seek medical services from a physician. Review different components of the form including chief complaint, history of medical conditions, allergies, medications, and injuries. The teacher reads questions and asks student to answer multiple choice answers.

Divide class into pairs and instruct to fill out form about somebody they know and themself. Tell students that the medical history can be real or imaginary. Each student asks partner questions about their form. The teacher then writes questions on the chalkboard as guidelines, common questions that patient may be asked during a medical appointment. The teacher then calls on a couple of pairs to share how they filled out their forms and review any needed corrections and difficulties understanding terms on the form.

NEW PATIENT MEDICAL HISTORY FORM

UNC PHYSICIANS NETWORK
UNC HEALTH CARE

Full Name: _____ Date: _____

Birth Date: _____ Age: _____

ALLERGIES ❑ NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS *(Please list ALL)*	DOSE *(Mg., pill, etc.)*	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information

HEALTH MAINTENANCE SCREENING TEST HISTORY

CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? Y N
COLONOSCOPY/SIGMOID	Date:	Facility/Provider:	Abnormal Result? Y N
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? Y N
BONE DENSITY	Date:	Facility/Provider:	Abnormal Result? Y N

VACCINATION HISTORY

Last Tetanus Booster or TdaP:	Last Pnuemovax *(Pneumonia)*:
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine *(Shingles)*:	

UNC PHYSICIANS NETWORK
UNC HEALTH CARE

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer *(type:_____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

SURGERIES

TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: ____ Age of Menopause: ____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

Patient Name: _____ DOB: _____

UNC PHYSICIANS NETWORK
UNC HEALTH CARE

FAMILY MEDICAL HISTORY ❑ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

✓ CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer (type:)	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other:	Other:	Other:
Mother																		
Father																		
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		
Other:_____																		

SOCIAL HISTORY

Occupation *(or prior occupation)*:	❑ Retired ❑ Unemployed ❑ LOA ❑ Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift? Y N N/A	
Marital Status *(check one)*: ❑ Single ❑ Partner ❑ Married ❑ Divorced ❑ Widowed ❑ Other:_____	
Do you have children? Y N	If yes, how many?

OTHER HEALTH ISSUES

TOBACCO USE	Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)*		
Current: Packs/day ____ # of Years ____	***Past:*** Quit Date: _____ Packs/day ____ # of Years ____		
Other Tobacco *(check one)*: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew			
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	❑ Beer ❑ Wine ❑ Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N	Have you ever used needles to inject drugs? Y N		
Have you ever taken someone else's drugs? Y N			

Patient Name: _____ DOB: _____

UNC PHYSICIANS NETWORK
UNC HEALTH CARE

OTHER HEALTH ISSUES continued...

SEXUAL ACTIVITY	Sexually involved currently? Y N *(If no sexual history, please continue to Exercise)*		
Sexual partner(s) is/are/have been: ❑ Male ❑ Female			
Birth control method: ❑ None ❑ Condom ❑ Pill/Ring/Patch/Inj/IUD ❑ Vasectomy			
EXERCISE	Do you exercise regularly? Y N *(If you answered no, please move to Sleep)*		
What kind of exercise?		***Duration:*** How long (min.): _____ How often: _____	
SLEEP	How many hours, on average, do you sleep at night *(or during the day, if working night shift)*?		
DIET	How would you rate your diet? ❑ Good ❑ Fair ❑ Poor	Would you like advice on your diet? Y N	
SAFETY	Do you use a bike helmet? Y N	Do you use seat belts consistently? Y N	
Working smoke detector in home? Y N		If you have guns at home, are they locked up? Y N	
Is violence at home a concern for you? Y N		Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N	

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other:_____		
Other:_____		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?

Patient Name: _____ DOB: _____

UNC PHYSICIANS NETWORK
UNC HEALTH CARE

REVIEW OF SYSTEMS ✔ CHECK ALL THAT APPLY

CONSTITUTION	CARDIOVASCULAR	SKIN
☐ Activity change	☐ Chest pain	☐ Color change
☐ Appetite change	☐ Leg swelling	☐ Pallor
☐ Chills	☐ Palpitations	☐ Rash
☐ Diaphoresis	**Gastrointestinal**	☐ Wound
☐ Fatigue	☐ Abdominal distention	**ALLERGY/IMMUNO**
☐ Fever	☐ Abdominal pain	☐ Environmental allergies
☐ Unexpected weight change	☐ Anal bleeding	☐ Food allergies
HEAD, EAR, NOSE & THROAT	☐ Blood in stool	☐ Immunocompromised
☐ Congestion	☐ Constipation	**NEUROLOGICAL**
☐ Dental problem	☐ Diarrhea	☐ Dizziness
☐ Drooling	☐ Nausea	☐ Facial asymmetry
☐ Ear discharge	☐ Rectal pain	☐ Headaches
☐ Ear pain	☐ Vomiting	☐ Light-headedness
☐ Facial swelling	**ENDOCRINE**	☐ Numbness
☐ Hearing loss	☐ Cold intolerance	☐ Seizures
☐ Mouth sores	☐ Heat intolerance	☐ Speech difficulty
☐ Nosebleeds	☐ Polydipsia	☐ Syncope
☐ Postnasal drip	☐ Polyphagia	☐ Tremors
☐ Rhinorrhea	☐ Polyuria	☐ Weakness
☐ Sinus pressure	**Genitourinary**	**HEMATOLOGIC**
☐ Sneezing	☐ Difficulty urinating	☐ Adenopathy
☐ Sore throat	☐ Dysuria	☐ Bruises/bleeds easily
☐ Tinnitus	☐ Enuresis	**PSYCHIATRIC**
☐ Trouble swallowing	☐ Flank pain	☐ Agitation
☐ Voice change	☐ Frequency	☐ Behavior problem
EYES	☐ Genital sore	☐ Confusion
☐ Eye discharge	☐ Hematuria	☐ Decreased concentration
☐ Eye itching	☐ Penile discharge	☐ Dysphoric mood
☐ Eye pain	☐ Penile pain	☐ Hallucinations
☐ Eye redness	☐ Penile swelling	☐ Hyperactive
☐ Photophobia	☐ Scrotal swelling	☐ Nervous/anxious
☐ Visual disturbance	☐ Testicular pain	☐ Self-injury
RESPIRATORY	☐ Urgency	☐ Sleep disturbance
☐ Apnea	☐ Urine decreased	☐ Suicidal ideas
☐ Chest tightness	**MUSCULAR**	
☐ Choking	☐ Arthralgias	
☐ Cough	☐ Back pain	
☐ Shortness of breath	☐ Gait problems	
☐ Stridor	☐ Joint swelling	
☐ Wheezing	☐ Myalgias	
	☐ Neck pain	
	☐ Neck stiffness	

Patient Name: _____ DOB: _____

The Doctor's Office

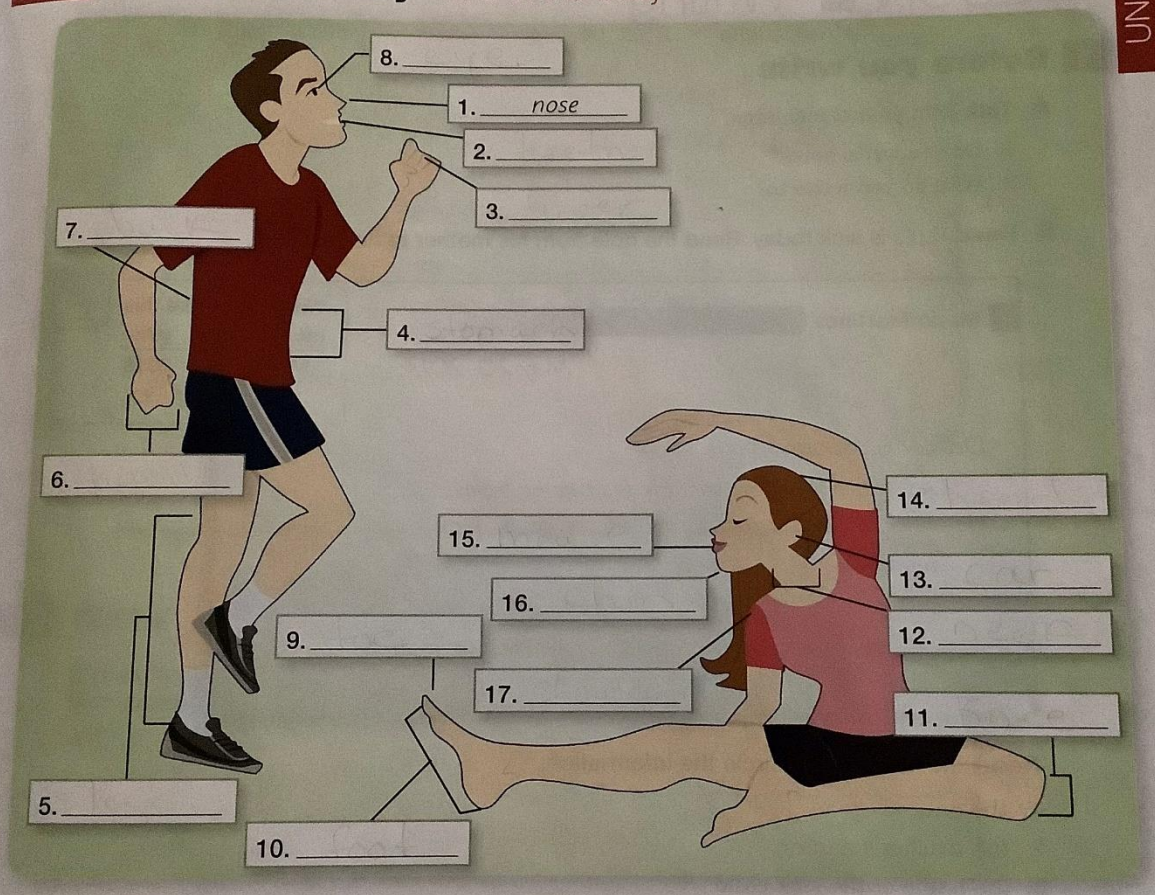
Poor Maria! Everyone is sick! Maria and her children are in the doctor's office. Her son, Luis, has a sore throat. Her daughter, Rosa, has a stomachache. Her baby, Gabriel, has an earache. Maria doesn't have a sore throat. She doesn't have a stomachache. And she doesn't have an earache. But Maria has a very bad headache!

After you read

A **Read** the sentences. Are they correct? Circle *Yes* or *No*.

1. Maria and her children are at school.	Yes	(No)
2. Luis has a backache.	Yes	No
3. Rosa has a headache.	Yes	No
4. Gabriel has an earache.	Yes	No
5. Maria has a bad headache.	Yes	No
6. Everyone is happy today.	Yes	No

4 Picture dictionary Parts of the body



STUDENT TK 21
CLASS CD1 TK 37

A Write the words in the picture dictionary. Then listen and repeat.

back	ear	finger	hand	knee	mouth	nose	stomach	toe
chin	eye	foot	head	leg	neck	shoulder	teeth	

LESSON B I have

1 Grammar focus: simple present of *have*

Statements

I	**have**	a cold.
You	**have**	
He	**has**	
She	**has**	

Turn to page 144 for a complete grammar chart.

USEFUL LANGUAGE

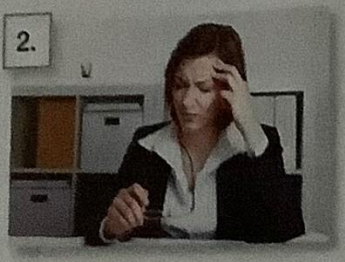
I have a terrible cold.
I have a bad headache.

2 Practice

A Write. Complete the sentences. Use *has* or *have*.

1. 

He *has* a terrible cold.

2. 

I _____ a headache.

3. 

He _____ a backache.

4. 

You _____ a fever.

5. 

I _____ a broken arm.

6. 

He _____ a stomachache.

7. 

She _____ a bad cough.

8. 

You _____ a sore throat.

9. 

She _____ a cut.

Listen and repeat.

Medical History Form

1. Chief complaint: Describe the problem and approximately when it began.

Problem	Date problem began

2. Have you ever had any of the following?

☐ allergies	☐ back pain	☐ frequent headaches	☐ high blood pressure
☐ arthritis	☐ chest pains	☐ heart attack	☐ high cholesterol
☐ asthma	☐ diabetes	☐ heart disease	☐ tuberculosis

3. Are you pregnant? Yes No

4. Are you currently taking medications? Yes No

5. If yes, list all medications, including vitamins and herbal supplements.

_____

6. List any major illness, injury, or surgery that you have had in the past year.

_____

The above information is correct to the best of my knowledge.

7. Signature: _____ 8. Date: _____