**Medical History Practice A**

**Intermediate Low**

**Directions:** Please complete the Medical History Form on the next page using the following information.

Today is November 26, 2019. Your name is Mr. John Peters. You are at the hospital for an asthma attack. You used your inhaler. However, you continue to have trouble breathing deeply. Your address is 678 Pine Street, San Gabriel, California, 91778. Your birthdate is July 22, 1978. You are 41 years old. Your home phone number is 626-565-4321. You do not smoke. You do not drink alcohol. You drink soda and coffee.

You take one vitamin every day and steroids for your asthma. You are allergic to eggs. The name of your primary care doctor is Tom Daniel. The address of Dr. Daniel’s office is 1245 Maple Drive in San Gabriel. Dr. Daniel’s office number is 626-555-5555.

You had one operation in the past. You had an appendix operation in 2002 at San Gabriel Valley Medical Center. Because it was over 5 years ago, you do not remember the doctor’s name.

In the past, you had mumps and last year you had chickenpox. You had a physical examination January 12, 2013. You have medical insurance through your employer. The name of the company is Health Smart. The group number is 9781234.

In case of an emergency, the hospital should call your wife, Sally Peters. Her telephone number is 626-555-1234.

**Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL HISTORY PRACTICE A**

**Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REASON FOR VISIT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICATIONS Please list the name: Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_**

**1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_**

**2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you drink soda/coffee? Yes \_\_\_\_\_ No \_\_\_\_\_**

**ALLERGIES**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OPERATIONS YEAR DOCTOR HOSPITAL**

**1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**In Case of Emergency**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Physician**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address and City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of last physical examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Past illnesses: Check Yes or No for each.**

**Influenza \_\_\_Yes \_\_\_No Diabetes \_\_\_Yes \_\_\_No Measles \_\_\_Yes \_\_\_No**

**Heart attack \_\_\_Yes \_\_\_No Strokes \_\_\_Yes \_\_\_No High blood pressure \_\_\_Yes \_\_\_No**

**Tuberculosis \_\_\_Yes \_\_\_No Pneumonia \_\_\_Yes \_\_\_No Thyroid disorder \_\_\_Yes \_\_\_No**

**Cancer \_\_\_Yes \_\_\_No Chickenpox\_\_\_Yes \_\_\_No Asthma\_\_\_Yes \_\_\_No**

**Mumps \_\_\_Yes \_\_\_No Ulcers \_\_\_Yes \_\_\_No Whooping Cough \_\_\_Yes \_\_\_No**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Date**

**Medical History Form Questions**

**Directions:** Answer the questions individually. After answering the questions, work in a small group to discuss all 10 answers.

1. When is John’s birthdate?
2. Does he smoke or drink alcohol?
3. What is he allergic to?
4. What is the name and telephone number of his primary care doctor?
5. What illnesses did he have in the past?
6. Does he have insurance?

***Now answer about you….***

1. Do you know someone who has asthma?
2. Do you drink coffee or soda regularly?
3. Do you think it is OK to give children under 5 years of age coffee or soda?
4. Are you allergic to any medication or food?

**MEDICAL HISTORY PRACTICE A – ANSWER KEY**

**Patient’s Name \_\_\_John Peters (1)\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_41 (2)\_\_ Sex \_M (3)\_ Today’s Date\_\_11/26/19 (4)\_\_**

**Address 678 Pine Street (5) City\_San Gabriel (6) State\_CA (7)\_ Zip 91778 (8) Phone \_626-565-4321 (9)**

**Birthdate \_\_7-22-78 (10)\_\_\_ Medical Insurance Company\_\_\_\_Health Smart (11)\_\_ Group # \_\_\_9781234 (12)\_\_**

**REASON FOR VISIT \_\_\_I am having an asthma attack. / asthma attack / (13)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICATIONS Please list the name: Do you smoke? Yes \_\_\_\_\_ No \_✔ (15)\_\_**

**1. \_steroids (14)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you drink alcohol? Yes \_\_\_\_\_ No \_✔ (16)\_\_**

**2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you drink soda/coffee? Yes \_✔ (17)\_\_ No \_\_\_\_\_**

**ALLERGIES**

**\_\_\_\_\_eggs (18)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OPERATIONS YEAR DOCTOR HOSPITAL**

**1. \_Appendix (19)\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_2002 (20)\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_ San Gabriel Valley Medical Center (21)**

**2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**In Case of Emergency**

**Name\_\_Sally Peters (22)\_\_\_\_\_\_\_ Relationship \_\_\_\_wife (23)\_\_\_\_\_Telephone Number \_626-555-1234 (24)\_**

**Primary Care Physician**

**Name: \_\_\_\_\_\_\_\_\_Tom Daniel (25)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_626\_) \_555-5555 (26)\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address and City: \_\_1245 Maple Drive San Gabriel, CA (27)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of last physical examination: \_\_\_01/12/13 (28)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Past illnesses? (only the indicated check marks are graded)**

**Influenza \_\_\_Yes \_\_\_No Diabetes \_\_\_Yes \_\_\_No Measles \_\_\_Yes \_\_\_No**

**Heart attack \_\_\_Yes \_\_\_No Strokes \_\_\_Yes \_\_\_No High blood pressure \_\_\_Yes \_\_\_No**

**Tuberculosis \_\_\_Yes \_\_\_No Pneumonia \_\_\_Yes \_\_\_No Thyroid disorder \_\_\_Yes \_\_\_No**

**Cancer \_\_\_Yes \_\_\_No Chickenpox\_✔(29)Yes \_\_\_No Asthma✔(30)Yes \_\_\_No**

**Mumps \_✔(27)Yes \_\_\_No Ulcers \_\_\_Yes \_\_\_No Whooping Cough \_\_\_Yes \_\_\_No**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Date**