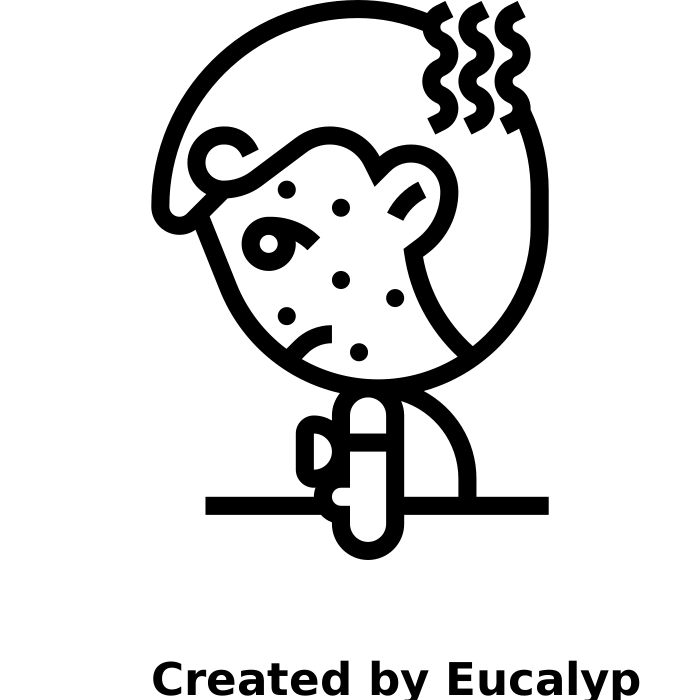
**Medical History Practice A**

**Intermediate Low**

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

Today is December 2, 2019. You are Miss Susan Johnson. You are 27 years old. You are at the hospital for a medical problem. Your address is 5789 Santa Anita Ave. in El Monte, CA 91732. You have brown hair and eyes. Your date of birth is May 30, 1992.

You are at the hospital today because you have a fever and started getting red spots throughout your body and face. The trouble started a few days ago.

You don’t smoke. You sometimes drink beer or wine on the weekend with your friends. You have a good diet and you don’t drink any soda or coffee. You like to take care of yourself. Therefore, you take a multivitamin every day. You are allergic to peanuts and penicillin. Your phone number is 626-555-1784.

Your primary care physician is Dr. Janet Green. Dr. Green’s office address is

1593 Main St. in Monterey Park, California 91754. Her telephone number is

626-578-8956.

In 2012, you had an operation on your arm to reset a broken bone after an accident. You also had severe headaches and neck pain. You were at Huntington Hospital at 100 W. California Ave. in Pasadena. The name of the doctor was Dr. Nguyen.

In the past, you had whooping cough and pneumonia. You got a new job in July 2016. Your new employer required you to get a physical exam. A week before you started your new job, you had a physical exam on August 5, 2016. You have Blue Shield medical insurance through your employer. The group number is 57892-B. In case of an emergency, the doctor should call your husband Alex Johnson at 626-896-8753.

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

**MEDICAL HISTORY PRACTICE B**

**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 Please list any allergies.**

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

**OPERATIONS Please list most recent by NAME YEAR DOCTOR HOSPITAL**

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

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

**IN CASE OF EMERGENCY Who should be called?**

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

**PRIMARY CARE PHYSICIAN**

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

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

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

**PAST ILLNESS Please mark all that apply.**

**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. Why is Susan at the hospital?
2. Why does she take a vitamin every day?
3. What illness did she have in the past?
4. Why did she have surgery on her arm?
5. Why did she get a physical examination?

***Answer about you….***

1. How often do you need to see a doctor?
2. Have you or a family member been in a car accident?
3. Do you take vitamins every day?
4. Do you think it is necessary to take a daily vitamin?
5. Have you ever had the measles?

**MEDICAL HISTORY PRACTICE B – ANSWER KEY**

**Patient’s Name \_\_\_Susan Johnson (1)\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_27 (2)\_\_ Sex \_F (3)\_ Today’s Date\_\_12/2/19 (4)\_\_**

**Address 5789 Santa Anita Ave (5) City\_El Monte (6) State\_CA (7)\_ Zip 91732 (8) Phone \_626-555-1784 (9)**

**Birthdate \_\_5-30-92 (10)\_\_\_ Medical Insurance Company\_\_\_\_Blue Shield (11)\_\_\_\_\_\_ Group # \_\_\_57892-B (12)\_\_**

**REASON FOR VISIT \_\_\_I have a fever and red spots. / fever and red spots (13)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICATIONS Please list the name: Do you smoke? Yes \_\_\_\_\_ No \_✔ (14)\_**

**1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you drink alcohol? Yes \_✔ (15)\_ No \_\_\_\_\_**

**2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you drink soda/coffee? Yes \_\_\_\_\_ No \_✔ (16)\_\_**

**ALLERGIES Please list any allergies.**

**\_\_\_\_\_peanuts and penicillin (17)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OPERATIONS Please list most recent by NAME YEAR DOCTOR HOSPITAL**

**1. \_reset broken arm (18)\_\_\_\_\_ \_\_2012 (19)\_\_\_\_ \_\_Dr. Nguyen (20)\_ \_Huntington Hospital(21)\_\_\_\_\_**

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

**IN CASE OF EMERGENCY Who should be called?**

**Name\_\_Alex Johnson (22)\_\_\_\_\_\_\_ Relationship \_\_\_\_husband (23)\_\_\_\_\_Telephone Number \_626-896-8753 (24)\_**

**PRIMARY CARE PHYSICIAN**

**Name: \_\_\_\_\_\_\_\_\_Dr. Janet Green (25)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_626\_) \_578-8956 (26)\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address and City: \_\_1593 Main St. Monterey Park, CA 91754 (27)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of last physical examination: \_\_\_08/5/16 (28)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PAST ILLNESS Please mark all that apply.(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 \_✔(29)Yes \_\_\_No Thyroid disorder \_\_\_Yes \_\_\_No**

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

**Mumps \_\_\_Yes \_\_\_No Ulcers \_\_\_Yes \_\_\_No Whooping Cough \_✔(30)Yes\_\_\_\_No**

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

**Signature Date**