**EL Civics 28.5 Medical History Form**

**Practice A**

**Advanced**

**Directions:** You are at the hospital for a medical problem. Please complete the medical history form.

Today is Thursday September 10, 2019. You are Mrs. Dana Delong. You are at the hospital today because you have a terrible headache. The trouble started a few days ago when you fell. Your address is 123 Bayberry Drive in Alhambra, CA 91801. You were born on July 12, 1949.

You don’t smoke, but you smoked in the past for five years. You drink a glass of wine once a week. You have a good diet, and you don’t drink any caffeine. You have diabetes and inject 5 units of insulin per day and carry it with you. You are allergic to strawberries and penicillin.

Your primary care physician is Dr. Jane Henderson. Your physician’s office is located at 1234 La Casa Via Drive in West Covina, and her telephone number is

626-231-6778.

You went to Queen of the Valley Hospital twice in the past. You had a tonsillectomy, which is surgery to remove your tonsils, in 2015. You were not hospitalized overnight but were in the outpatient clinic. The doctor who performed the surgery was Dr. John Laramie. In January 2011, you were in the hospital with severe pain in your back. You stayed two nights because you couldn’t walk. You had an x-ray at that time.

Your parents had heart disease, strokes, diabetes, and high blood pressure. When you were a child, you had mumps and measles. You also used to have ear infections.

Your last physical examination was June 14, 2010. You have Blue Heart health insurance. Your Group number is 975864.

Your home phone number is 626-555-8956. Your cell phone number is 626-895-5623. Your husband died 5 years ago, and you have never remarried. In case of emergency, your friend-Linda Ford 626-586-5265 should be contacted.

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

**Medical History Form Practice A**

Patient Name: Date:

(Last) (First) (Middle)

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_

Home Telephone: Cell Phone:

Date of Birth: / / Gender: Marital Status:

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured: Yes \_\_\_\_ No \_\_\_\_\_ Name of Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: List any medications you currently take, dosage and times taken each day:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any medications? \_\_\_\_\_\_\_\_\_\_ If yes, which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to anything else? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lifestyle:**

Do you smoke? How many per day: Number of years smoked:

Do you consume alcohol? Drinks per day:

Do you consume caffeine? Drinks per day:

How often do you exercise? Do you sleep well?

Are you currently under medical care for any reason? If yes, please explain:

Date of last examination by a doctor: / /

Primary Care Physician: Name:

Address: Telephone:

**Illness or Operation:**

Please list all operations:

Operation Year Hospital Doctor

Please list all times you have been admitted to a hospital overnight (except for childbirth)

Reason Hospitalized Year Hospital Doctor

Please check if any relatives (parents, siblings, grandparents, children) had any of the conditions listed below:

High blood pressure: Kidney disease: Asthma:

Stroke: Bleeding Tendencies: Tuberculosis:

Cancer: Seizures: Colitis:

Emphysema: Heart disease: Anemia:

Ulcers: Diabetes: Gout:

Mental Illness: Other Serious Illness:

Did you have any of the following illnesses? (Please circle if yes.)

Measles Diabetes Typhoid Chickenpox

Rubella (German Measles) Hives Malaria Allergies

Whooping Cough Hepatitis Depression Seizures

Mumps Heart Disease Tonsillitis Rheumatic Fever

Bronchitis Tuberculosis Asthma High Blood Pressure

Ear Infections Heart Attack Glaucoma Cancer

Stroke Pneumonia Eating Disorder Mono

Other serious illnesses:

Emergency contact information:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list the date and the results (if known) of your last:

X-ray:

EKG:

Blood Count:

*It should be noted that medications may have unwanted side effects. You are strongly urged to bring to our attention any problem that you may be having with your medications*.

Signature Date

**Medical History Form Questions**

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

1. What are Dana’s height and weight?

1. When did she fall?

1. What does she carry for her diabetes?

1. What is the name and telephone number of her primary care physician?

1. Why did she go to the hospital in 2011?

1. Does she have medical insurance?

1. Who is her insurance carrier?

**Medical History Form Practice A – ANSWER KEY**

Patient Name: **Delong Dana** **(1)** Date: **9/10/19** **(2)**

(Last) (First) (Middle)

Street Address: **123 Bayberry Dr. (3)** City: **Alhambra\_\_(4)\_\_** State **CA\_(5)\_** Zip Code **91801\_(6)\_**

Home Telephone: **626-555-8956 (7)** Cell Phone: **626-895-5623 (8)**

Date of Birth: **07 or 7 / 12 / 49 (9)** Gender: **female or woman (10)** Marital Status:**widow (11)**

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured: Yes \_**X (12)**\_ No \_\_\_ Name of Insurance Company **Blue Heart (13)** Group #\_**975864 (14)**

Reason for Visit \_ **headache/terrible headache/I have a terrible headache (15)**\_\_\_\_\_\_\_\_\_\_\_\_

Medications: List any medications you currently take, dosage and times taken each day:

**Insulin, 5 units per day (16)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any medications? \_\_**Yes (17)**\_\_\_\_ If yes, which ones?\_\_**penicillin (18)**\_\_\_\_\_\_\_

Are you allergic to anything else? \_\_\_\_**Yes (19)**\_\_\_\_ If yes, please explain: \_**strawberries (20)**\_\_\_

**Lifestyle:**

Do you smoke? **No (21)** How many per day: Number of years smoked:

Do you consume alcohol? **Yes (22)** Frequency: **One glass per week (23)**

Do you consume caffeine? **No (24)** Frequency:

How often do you exercise? Do you sleep well?

Are you currently under medical care for any reason? If yes, please explain:

Date of last examination by a doctor: **6 / 14 / 10 (25)**

Primary Care Physician: Name: **Jane Henderson (26)**

Address: **1234 La Casa Via Drive, West Covina (27)** Telephone: **626-231-6778 (28)**

**Illness or Operation:**

Please list all operations:

Operation Year Hospital Doctor

**Tonsillectomy (29)** **2015 (30)** **Queen of the Valley (31)** **Dr. John Laramie (32)**

Please list all times you have been admitted to a hospital overnight (except for childbirth)

Reason Hospitalized Year Hospital Doctor

**Severe back pain (33)** **2011 (34)** **Queen of the Valley (35)**

Please check if any relatives (parents, siblings, grandparents, children) had any of the conditions listed below: **(only the indicated check marks are graded)**

High blood pressure:**✔(36)** Kidney disease: Asthma:

Stroke: **✔(37)**  Bleeding Tendencies: Tuberculosis:

Cancer: Seizures: Colitis:

Emphysema: Heart disease: **✔(38)**  Anemia:

Ulcers: Diabetes: **✔(39)**  Gout:

Mental Illness: Other Serious Illness:

Did you have any of the following illnesses? (Please circle if yes.)**(only the indicated are graded)**

**Measles (40)** **Diabetes (43)** Typhoid Chickenpox

Rubella (German Measles) Hives Malaria Allergies

Whooping Cough Hepatitis Depression Seizures

**Mumps (41)** Heart Disease **Tonsillitis (44)** Rheumatic Fever

Bronchitis Tuberculosis Asthma High Blood Pressure

**Ear Infections (42)** Heart Attack Glaucoma Cancer

Stroke Pneumonia Eating Disorder Mono

Other serious illnesses:

Emergency contact information:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list the date and the results (if known) of your last:

X-ray: **2011 (45)**

EKG:

Blood Count:

*It should be noted that medications may have unwanted side effects. You are strongly urged to bring to our attention any problem that you may be having with your medications.*

Signature Date