**EL Civics 28.5 Medical History Form**

**Practice B**

**Advanced**

**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 after you went on vacation to the Caribbean.

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 only drink caffeine free drinks. You like to take care of yourself. Therefore, you take a multivitamin every day and do yoga 4-6 days a week. You recommend yoga to all your friends. You tell them that you have greater flexibility and sleep deeply. You are allergic to peanuts and penicillin. Your home phone number is 626-555-1784. Your cell phone number is 626-896-8853.

Your primary care physician is Dr. Janet Green. Dr. Green’s office address is located at 1593 Main St. in Monterey Park, California 91754. Her telephone number is 626-578-8956. Because you are healthy, you do not see your doctor on a regular basis.

In 2012, you had an operation on your arm to reset a broken bone after a car 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 have a family history of diabetes and high blood pressure which concerns you. You eat a healthy diet and exercise regularly to prevent these family illnesses.

You got a new job in July 2016. Your new employer, The Huntington Library, required you to get a physical exam as a condition of employment. A week before you started your new receptionist 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 Form Practice B**

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? Frequency:

Do you consume caffeine? 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: / /

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)

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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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, 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 Form Practice B – ANSWER KEY**

Patient Name: **Johnson** **Susan** **(1)** Date: **12/2/19 (2)**

 (Last) (First) (Middle)

Street Address: \_**5789 Santa Anita Ave. (3)**\_ City: \_\_\_**El Monte (4)**\_ State \_**CA (5)**\_ Zip Code \_**91732 (6)**\_

Home Telephone: **626-555-1784 (7)** Cell Phone: **626-896-8853 (8)**

Date of Birth: **5**/**30**/**92 (9)** Gender: **female or woman (10)** Marital Status: **married (11)**

Occupation \_\_\_**receptionist (12)**\_\_\_\_\_\_ Employer \_\_\_\_**Huntington Library (13)**\_\_\_\_\_\_\_\_\_\_\_

Insured: Yes **✔ (12)\_** No \_\_\_\_ Name of Insurance Company \_**Blue Shield (13)**\_ Group #\_**57892-B (14)**\_

Reason for Visit \_\_\_\_\_**I have a fever and red spots on my face./fever and red spots on face (15)**\_\_\_\_\_\_

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

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

Are you allergic to any medications? \_\_**Yes (16)**\_\_ If yes, which ones? \_\_\_\_\_**penicillin (17)**\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to anything else? \_\_\_**Yes (18)**\_\_\_\_\_\_\_\_\_\_\_ If yes, please explain: \_\_**peanuts (19)**\_\_\_\_\_\_\_\_

**Lifestyle:**

Do you smoke? **No (20)** How many per day: Number of years smoked:

Do you consume alcohol? **Yes (21)** Frequency: **some weekends (22)**

Do you consume caffeine? **No (23)** Frequency:

How often do you exercise? **4-6 days a week (24)** Do you sleep well? **Yes (25)**

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

Date of last examination by a doctor: **08** /**05** /**16 (26)**

Primary Care Physician: Name: **Dr. Janet Green (27)**

Address: **1593 Main St. Monterey Park, CA 91754 (28)** Telephone: **626-578-8956 (29)**

**Illness or Operation:**

Please list all operations:

 Operation Year Hospital Doctor

**reset a broken arm (30)** **2012 (31)** **Huntington Hospital (32)** **Dr. Nguyen (33)**

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:

**(only the indicated check marks are graded)**

High blood pressure: **✔ (34)**  Kidney Disease: Asthma:

Stroke: Bleeding Tendencies: Tuberculosis:

Cancer: Seizures: Colitis:

Emphysema: Heart Disease: Anemia:

Ulcers: Diabetes: **✔ (35)**  Gout:

Mental Illness: Other Serious Illness:

Did you have any of the following illnesses: (Please Circle) **(only the indicated are graded)**

Measles Diabetes Typhoid Chickenpox

Rubella (German Measles) Hives Malaria Allergies

**Whooping Cough (36)** Hepatitis Depression Seizures

Mumps Heart Disease Tonsillitis Rheumatic Fever

Bronchitis Tuberculosis Asthma High Blood Pressure

Ear Infections Heart Attack Glaucoma Cancer

Stroke **Pneumonia (37)** Eating Disorder Mono

Other serious illnesses:

Emergency contact information:

Name: \_\_\_**Alex Johnson (38)**\_\_\_ Relationship: \_\_\_\_**husband (39)**\_\_ Phone number: **626-896-8753 (40)**

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