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| **EL Civics Objective 28 (Health Care) – IL4 Task 1: Complete a Medical History Form** |
| **Language & Literacy Objectives:**  Complete a medical health history form.  Describe symptoms of an illness. |
| **INTRODUCTION** |
| Students will learn the information they are expected to provide when visiting a doctor’s office, urgent care or hospital. In addition, students will learn how to describe their past health history, as well as current symptoms, in order to complete an authentic (adapted) medical health form. |
| **ASSESSMENT TASK (18 points possible)** |
| The related task on the assessment requires students to use a provided personal history to fill out an authentic medical history form. The number and complexity of items is adapted for each language level. |
| **SUGGESTED ACTIVITIES** |
| * Review parts of the body and common ailments, illnesses & diseases. * Review the completed sample medical history form provided (Handout 4). Project it or give students print copies and ask questions about the patient. “When was Michael’s last medical exam?” “Has he ever had cancer? If so, what kind?” “Is his mother living? If so, does she have any health problems?” * After reviewing the “Michael Simpson” sample, have the students practice filling out their own medical history forms. Encourage them to create a “master” form to take to their doctor’s office, the hospital, etc. |

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| **HANDOUTS PROVIDED** |
| 1. Related Vocabulary 2. Discussion Questions 3. Introduction: Medical Health History 4. Comprehension: Read a Medical History Form 5. Practice: Fill in a Medical Healthy History Form 6. Additional Resources: Blank Medical History Forms |
| **COMPUTER LAB ACTIVITIES** |
| * Use web-based activities to review parts of the body, ailments, illnesses and diseases. * Create refrigerator magnet with list of local healthcare providers. * Create a detailed “master” form to take to doctor’s office, etc. Type so that anyone else can clearly read if necessary. * Use the following website to create a family medical history:  [Surgeon General’s My Family Health Portrait](https://curehht.org/resource/family-health-portrait/) |

**Related Vocabulary**

**form**: document with blank spaces to write or type information

**fill out**: to complete (a form, for example) by providing required information.

**medical/health history**: summary of your symptoms, past illnesses & treatments, surgeries, ongoing diseases, & diseases that run in your family. Guide for your doctor.

**medications**: prescription and over-the-counter drugs taken to relieve symptoms or treat a disease or illness

**surgery**: operation or procedure, especially involving removal or replacement of a diseased organ or tissue

**hospitalization**: period of stay in a hospital

**reason for visit**: why you need to see the doctor now

**symptoms**: a subjective indication of a disorder or disease, such as pain, nausea or weakness. May be accompanied by objective signs of disease such as abnormal lab test results or findings during a physical examination.

* ***headaches****: pain in the head (over the eyes, at the temples, or at the base of the skull)*
* ***chest pain****: pain in the chest*
* ***shortness of breath****: difficulty in drawing sufficient breath; labored breathing*
* ***insomnia****: chronic inability to fall asleep or remain asleep for an adequate length of time*
* ***nausea/vomiting****: sickness in the stomach/ejecting the stomach’s contents through the mouth*
* ***vision problems****: eye disturbances, including blurred vision, halos and blind spots*
* ***sore throat****: painful or sensitive condition of the throat exaggerated by swallowing or talking*
* ***fatigue/weakness****: weariness or exhaustion from labor, exertion, or stress; lacking strength*
* ***weight loss:***  *reduction of body weight to improve health; takes place when you use more calories to exist than you take in. Calories necessary for each person based on age, height, weight, genetics and lifestyle (e.g. amount of exercise).*

**health insurance**: insurance that compensates the insured for expenses or loss incurred for medical reasons, as through illness or hospitalization.

**name of insured**: person who is covered by an insurance policy.

**employer name**: person or business that provides your insurance policy.

**insurance carrier**: insurance company; insurer

**group number (no.)**: reference number for large number of people covered under the same insurance policy

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**Discussion Questions: Medical Health History**

1. What are the most common health problems in your native country?
2. Where do people go to get treated for these problems?
3. What are the differences in the ways health problems are treated in the U.S. and in your home country?
4. Do you go to an English-speaking doctor or medical clinic now? Where do you go?
5. Describe a time when you or a family member had a serious medical problem and needed emergency care.
6. Do you visit the doctor alone, or do you take someone who knows more English?
7. Have you ever filled out a medical history form? Were you able to complete it yourself, or did you need help from someone else (e.g. a family member)?

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**Introduction: Medical Health History**

A doctor wants to know about the illnesses and operations you have had. The doctor also needs information about any existing conditions (such as allergies), and about the symptoms you have now.

Usually, you will be asked to fill out forms giving your health history. It is a good idea to prepare/update your medical history at a time when you feel fine. That way, you can avoid language difficulties at a time when you don’t feel well and need medical help.

Common questions may include:

* When was your last medical exam?
* What medications are you taking?
* What illnesses have you had?
* What permanent conditions (like diabetes) do you have?
* What are your habits, such as:
* Do you drink? How much? How often?
* Do you smoke? How many packs a day?
* How often do you exercise?
* What surgeries have you had?
* Have you had a child? How many?
* What health problems run in your family?

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**Comprehension: Reading a Medical History Form**

Read the completed medical history form on the next page.

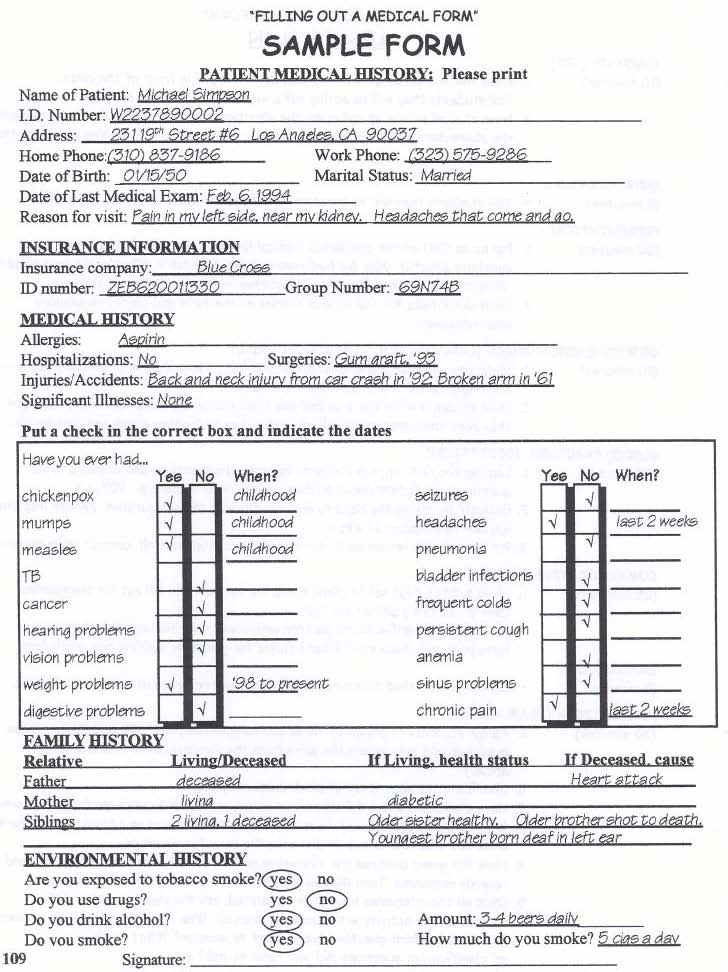
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| **Look for information about:** | **Hospitalizations & illnesses**  **Family health history**  **Insurance information**  **Allergies**  **Health habits (smoking, etc.)** |

**Answer the following questions:**

1. What is the patient’s full name?
2. Is the patient male or female?
3. When was the patient born?
4. How tall is the patient? How much does he weigh?
5. What is the patient’s home address?
6. What is the patient’s home phone number? Cell?
7. Has this patient had any surgeries? If so, which ones?
8. What is the patient’s reason for the current visit?
9. Is this patient covered by health insurance?

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**Comprehension: Reading a Medical History Form (cont.)**



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**Practice: Fill Out a Medical History Form**

***DIRECTIONS****: Sandy is at the doctor’s office. She needs your help to fill out her medical history form. Please use the information below:*

Sandra Michelle Jones was born August 31, 1970. She is 5’9” tall and weighs 150 lbs. Sandy lives at 22230 Anza Avenue, Torrance, CA 90502. Her home phone number is 310-555-2529 and her cell phone is 562-555-4891. She takes 20mg of Lipitor each day to lower her cholesterol. She had her tonsils removed in 1990. For three weeks, she has been having headaches and blurred vision. She has Blue Cross insurance through her employer, Toyota, group ID #336894.

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| **MEDICAL HISTORY FORM** | | | | | | | | | | | | | |
| **1. Name** *(Last, First, M.I.):* | |  | | | | **2.** 🞎 M 🞎 F | | | | **3. Date of Birth: (MM/DD/YYYY)** | | |  |
| **4. Height:** | |  | | | | | | **5. Weight:** | | | |  | |
| **6. Street Address:** | |  | | | | | | **7. City, State, Zip:** | | | |  | |
| **8. Home Phone:** | |  | | | | | | **9. Cell Phone:** | | | |  | |
| **PERSONAL HEALTH HISTORY** | | | | | | | | | | | | | |
| **List current medications** | | | | | | | | | | | | | |
| Name the Drug | | | | | | | | Strength | | | | | |
| **10.** | | | | | | | | **11.** | | | | | |
| **List past surgeries** | | | | | | | | | | | | | |
| Reason | | | | | | | | Year | | | | | |
| **12.** | | | | | | | | **13.** | | | | | |
| **REASON FOR TODAY’S VISIT** | | | | | | | | | | | | | |
| **14. Check your symptoms:** | | | | | | | | | | | | | |
| 🞎 | Headaches | | | 🞎 | Insomnia | | | | 🞎 | | Sore throat | | |
| 🞎 | Chest pain | | | 🞎 | Nausea/vomiting | | | | 🞎 | | Fatigue/weakness | | |
| 🞎 | Shortness of breath | | | 🞎 | Vision problems | | | | 🞎 | | Weight loss | | |
| **HEALTH INSURANCE** | | | | | | | | | | | | | |
| **15. Name of Insured:** | | |  | | | | **16. Employer Name:** | | | | |  | |
| **17. Insurance Carrier:** | | |  | | | | **18. Group No.** | | | | |  | |

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**Answer Key: Fill Out a Medical History Form**

***DIRECTIONS****: Sandy is at the doctor’s office. She needs your help to fill out her medical history form. Please use the information below:*

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| **MEDICAL HISTORY FORM** | | | | | | | | | | | | | | |
| **1. Name** *(Last, First, M.I.):* | | **Jones, Sandra M.** | | | | **2.** 🞎 M **🗹 F** | | | | **3. Date of Birth: (MM/DD/YYYY)** | | | | **08/31/1970** |
| **4. Height:** | | **5’9” (5 feet, 9 inches)** | | | | **5. Weight:** | | | | | | **150 lbs (pounds)** | | |
| **6. Street Address:** | | **22230 Anza Avenue** | | | | **7. City, State, Zip:** | | | | | | **Torrance, CA 90502** | | |
| **8. Home Phone:** | | **310-555-2529** | | | | **9. Cell Phone:** | | | | | | **562-555-4891** | | |
| **PERSONAL HEALTH HISTORY** | | | | | | | | | | | | | | |
| **List current medications** | | | | | | | | | | | | | | |
| Name the Drug | | | | | | | | Strength | | | | | | |
| **10. Lipitor** | | | | | | | | **11. 20mg** | | | | | | |
| **List past surgeries** | | | | | | | | | | | | | | |
| Reason | | | | | | | | Year | | | | | | |
| **12. Tonsils removed (Tonsillectomy)** | | | | | | | | **13. 1990** | | | | | | |
| **REASON FOR TODAY’S VISIT** | | | | | | | | | | | | | | |
| **14. Check your symptoms:** | | | | | | | | | | | | | | |
| **🗹** | **Headaches** | | | 🞎 | Insomnia | | | | 🞎 | | Sore throat | | | |
| 🞎 | Chest pain | | | 🞎 | Nausea/vomiting | | | | 🞎 | | Fatigue/weakness | | | |
| 🞎 | Shortness of breath | | | **🗹** | **Vision problems** | | | | 🞎 | | Weight loss | | | |
| **HEALTH INSURANCE** | | | | | | | | | | | | | | |
| **15. Name of Insured:** | | | **Sandra M. Jones** | | | | **16. Employer Name:** | | | | | | **Toyota** | |
| **17. Insurance Carrier:** | | | **Blue Cross** | | | | **18. Group No.** | | | | | | **336894** | |

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ADDITIONAL RESOURCES: MEDICAL HISTORY FORM 1

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History**: Circle any of the following that you have had.

|  |  |  |  |
| --- | --- | --- | --- |
| Allergies or Asthma | Congestive Heart Failure | Hemorrhoids | Migraines |
| Alcoholism | Depression | Hepatitis (Jaundice) | Phlebitis |
| Anemia | Diabetes | High Blood Pressure | Psoriasis |
| Arthritis | Drug Abuse | Heart Blockage | Hernia |
| Breast lumps/cysts | Eczema-Hives | Kidney Stones | Stroke |
| Cancer (Tumors) | Epilepsy or Seizures | Liver Disease | Suicide Attempt |
| Cataracts | Heart Attack | Lung Disease | Thyroid Disease |

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications:** [List all you are taking, the dosage (strength), and how often you take it.]

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Drug Allergies**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Review of Systems:

|  |  |  |  |
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| **Within the last 6 months have you had problems with** | Yes | No | Describe |
| General fatigue, weight loss, etc.) |  |  |  |
| Eyes (blurriness, burning, vision, etc.) |  |  |  |
| Ears, Nose, Throat  (drainage, bleeding, hard to swallow, etc.) |  |  |  |
| Lungs or Breathing  (shortness of breath, cough, wheeze, etc.) |  |  |  |
| Heart (chest pains, murmur, skipping, etc.) |  |  |  |
| Bones/Joints (swelling, stiffness, pain, etc.) |  |  |  |
| Skin (rashes, ulcers, etc.) |  |  |  |
| Depression, feeling uptight, sleep problems |  |  |  |
| Glands (problems with heat/cold, urine, eating, dry skin, hair change) |  |  |  |

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**ADDITIONAL RESOURCES: MEDICAL HISTORY FORM 2**

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| **HEALTH HISTORY QUESTIONNAIRE** | | | | | | | | | | | | | | | | | | |
| All questions contained in this questionnaire are strictly confidential  and will become part of your medical record. | | | | | | | | | | | | | | | | | | |
| **Name** *(Last, First, M.I.):* | | |  | | | | | 🞎 M 🞎 F | | **DOB:** | |  | | | | | | |
| **Marital status:** | | 🞎 Single 🞎 Partnered 🞎 Married 🞎 Separated 🞎 Divorced 🞎 Widowed | | | | | | | | | | | | | | | | |
| **Previous or referring doctor:** | | | | |  | | **Date of last physical exam:** | | | | | | |  | | | | |
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| **PERSONAL HEALTH HISTORY** | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **Childhood illness:** | | | 🞎 Measles 🞎 Mumps 🞎 Rubella 🞎 Chickenpox 🞎 Rheumatic Fever 🞎 Polio | | | | | | | | | | | | | | | |
| **Immunizations and dates:** | | | | 🞎 Tetanus | |  | 🞎 Pneumonia | | | |  | | | | | | | |
| 🞎 Hepatitis | |  | 🞎 Chickenpox | | | |  | | | | | | | |
| 🞎 Influenza | |  | 🞎 MMR *Measles, Mumps, Rubella* | | | | | |  | | | | | |
| **List any medical problems that other doctors have diagnosed** | | | | | | | | | | | | | | | | | | |
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| **Surgeries** | | | | | | | | | | | | | | | | | | |
| Year | Reason | | | | | | | | Hospital | | | | | | | | | |
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| **Other hospitalizations** | | | | | | | | | | | | | | | | | | |
| Year | Reason | | | | | | | | Hospital | | | | | | | | | |
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| **Have you ever had a blood transfusion?** | | | | | | | | | | | | | | | 🞎 | Yes | 🞎 | No |
|  | | | | | | | | | | | | | | | | | | |