

Healthcare – 28.5



Objectives: At the completion of this portfolio, you should be able to:

1. Develop a list of questions to ask community health care providers
2. Describe symptoms of an illness
3. Perform actions in response to a physician's instructions in a role play
4. Complete a medical history form
5. Make medical appointments and transfer appointment information onto a calendar

Tasks: You will demonstrate these skills by:

1. Making an appointment
2. Completing a medical history form
3. Role playing a visit to a doctor

Materials needed:

1. Audio tape and recorder

Task # 1 – Make an appointment

Instructions: Role-play making a call to the doctor’s office to schedule a medical appointment. The appointment should fit into the calendar provided. Make a note of the appointment time and date to transfer to the calendar. You should include the following information:

1. Appropriate phone greeting.
2. Your name
3. The reason for the appointment
4. The doctor’s name
5. The day, date, and time of the appointment
6. Appropriate phone closing.

Sun	Mon	Tues	Wed	Thurs	Fri	Sat
		1	2	3	4	5 10-2 soccer practice
6	7	8 8:00 dinner with John	9	10	11	12 10-2 soccer practice
13	14	15	16	17 6-7pm parent/teacher conference	18	19 10-2 soccer practice
20	21 8:30am pick up Amy from airport	22	23	24	25 11am drop off Amy at airport	26 10-2 soccer practice
27	28	29	30	31		

Making an Appointment - Sample Conversation

Doctor's office: "Good morning, Doctor Jones's office."

Patient: "Good morning, this is Mary Smith. I'm a patient of Dr. Jones"

Doctor's office: "Good morning. How may I help you?"

Patient: "I have a bad cold, and I would like an appointment with Doctor Jones."

Doctor's office: "We have an opening on Wednesday the 16th at 9:00 am."

Patient: "Do you have anything sooner?"

Doctor's office: "You can come in this Saturday at 3:00 if you prefer."

Patient: "Thank you. I will come in on Saturday the 12th at 3:00"

Doctor's office: "Please come half an hour early to fill out some forms."

Patient: "Ok. Thank you. Goodbye."

Note: This section will be audio taped. You will be scored on how much information you include in your telephone call.

Task # 2 – Complete a Medical History Form



Instructions: Fill out a medical history form for Mary Smith, using a real form from your doctor or the sample provided. (*Note: please do NOT use your real private information.*)

Mary Smith is a happily married mother of two. She was born on 4/12/68. Mary needs to go to the doctor because she has a bad cold. She has been coughing and sneezing and she has a sore throat. She has a fever of 100.2. Otherwise she is in good health, but her father suffers from diabetes and her sister has breast cancer. Mary does not smoke or drink alcohol, but she has one or two cups of coffee a day. She tries to stay healthy by taking vitamins, eating well, and exercising regularly.

Notes Page

Name _____

Date _____

Adult Health History Form

Your answers on this form will help your health care provider better understand your medical concerns and conditions better. This form will not be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. **Thank you!**

Age _____ How would you rate your general health? Excellent Good Fair Poor

Main reason for today's visit: _____

Other concerns: _____

REVIEW OF SYMPTOMS: Please check any current symptoms you have.

Constitutional

- ____ Recent fevers/sweats
- ____ Unexplained weight loss/gain
- ____ Unexplained fatigue/weakness

Respiratory

- ____ Cough/wheeze
- ____ Coughing up blood

Skin

- ____ Rash
- ____ New or change in mole

Eyes

- ____ Change in vision

Gastrointestinal

- ____ Heartburn/reflux
- ____ Blood or change in bowel movement
- ____ Nausea/vomiting/diarrhea
- ____ Pain in abdomen

Neurological

- ____ Headaches
- ____ Memory loss
- ____ Fainting

Ears/Nose/Throat/Mouth

- ____ Difficulty hearing/ringing in ears
- ____ Hay fever/allergies/congestion
- ____ Trouble swallowing

Genitourinary

- ____ Painful/bloody urination
- ____ Leaking urine
- ____ Nighttime urination
- ____ Discharge: penis or vagina
- ____ Unusual vaginal bleeding
- ____ Concern with sexual functions

Psychiatric

- ____ Anxiety/stress
- ____ Sleep problem

Cardiovascular

- ____ Chest pains/discomfort
- ____ Palpitations
- ____ Short of breath with exertion

Blood/Lymphatic

- ____ Unexplained lumps
- ____ Easy bruising/bleeding

Breast

- ____ Breast lump
- ____ Nipple discharge

Musculoskeletal

- ____ Muscle/joint pain
- ____ Recent back pain

Endo

- ____ Cold/heat intolerance
- ____ Increase thirst/appetite

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless? Yes No

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication	Dose (e.g., mg/pill)	How many times per day

Allergies or reactions to medications: _____

Date of your most recent **IMMUNIZATIONS:**

Hepatitis A _____ Hepatitis B _____ Influenza (flu shot) _____ MMR _____ Pneumovax (pneumonia) _____
 Meningitis _____ Tetanus (Td) _____ Varicella (chicken pox) shot or illness _____ Tdap (tetanus & pertussis) _____

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol) _____ Date _____ Abnormal? Yes No
Sigmoidoscopy _____ or *Colonoscopy* _____ Date _____ Abnormal? Yes No
 Women: *Mammogram* _____ Date _____ Abnormal? Yes No *Pap Smear* _____ Date _____ Abnormal? Yes No
Dexascan (osteoporosis) _____ Date _____ Abnormal? Yes No
 Men: *PSA* (prostate) _____ Date _____ Abnormal? Yes No

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with dates).

____ Heart disease: _____ ____ High blood pressure ____ High cholesterol
 specify type _____ ____ Diabetes ____ Thyroid problem
____ Asthma/Lung disease ____ Other: (specify): _____ ____ Kidney disease
____ Cancer: (specify): _____

SURGICAL HISTORY: Please list all prior operations (with dates):

FAMILY HISTORY: Please indicate the current status of your immediate family members:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism _____ High cholesterol _____
Cancer, specify type _____ High blood pressure _____
Heart disease _____ Stroke _____
Depression/suicide _____ Bleeding or clotting disorder _____
Genetic disorders _____ Asthma/COPD _____
Diabetes _____ Other: _____

SOCIAL HISTORY

Tobacco Use

Cigarettes Never Quit Date _____
 Current Smoker: packs/day _____ # of yrs _____
Other Tobacco: Pipe Cigar Snuff Chew
Are you interested in quitting? No Yes

Alcohol Use

Do you drink alcohol? No Yes # drinks/week _____
Is your alcohol use a concern for you or others? No Yes

Drug Use

Do you use any recreational drugs? No Yes
Have you ever used needles to inject drugs? No Yes

Sexual Activity

Sexually active: Yes No Not currently
Current sex partner(s) is/are: male female
Birth control method: _____ None needed
Have you ever had any sexually transmitted diseases (STDs)?
 No Yes
Are you interested in being screened for sexually transmitted diseases? No Yes

SOCIOECONOMICS

Occupation: _____ Employer: _____
Years of education/highest degree: _____ Marital Status: Single Partner/Married Divorced Widowed Other: _____
Spouse/partner's name: _____ Number of children/ages: _____
Who lives at home with you? _____

WOMEN'S HEALTH HISTORY

pregnancies _____ # deliveries _____ # abortions _____ # miscarriages _____
Age at start of periods: _____ Age at end of periods: _____

OTHER CONCERNS

Caffeine Intake: None Coffee/tea/soda _____ cups/day

Weight: Are you satisfied with your weight? No Yes

Diet: How do you rate your diet? Good Fair Poor
Do you eat or drink four servings of dairy or soy daily or take calcium supplements? No Yes

Exercise: Do you exercise regularly? No Yes

What kind of exercise? _____

How long (minutes) _____ How often? _____

If you do not exercise, why? _____

Safety: Do you use a bike helmet? No Yes NA

Do you use seatbelts consistently? No Yes

Is violence at home a concern for you? Yes No

Have you ever been abused? Yes No

Do you have a gun in your home? Yes No

Have you completed a living will or durable power of attorney for health care? Yes No

Task # 3 – Visiting the Doctor

Instructions:

Part 1: Role play a visit to your doctor. Your tutor will role-play the doctor. You should include the following information:

1. Greet the doctor and introduce yourself
2. Description of the illness or symptoms (sample: I have a sore throat.):
 - 1) _____

 - 2) _____

3. Doctor's questions (sample: Do you have a fever?)
 - 1) _____

 - 2) _____

4. Thank you and goodbye

Note: This section will be audio taped.

Part 2: Your tutor will ask you comprehension questions about the doctor's diagnosis and instructions. Answer orally.

Question 1: _____

Question 2: _____

Note: This section will be audio taped.