Fill out this chart for Rita's Family Health History:

Condition	Any Family History?	Family Member with Condition
High Blood Pressure		
Heart Disease		
Diabetes		
Breast Cancer		

Vocabulary:
Siblings
Runs in the family
Family history

Practice this conversation with your partner:

Nurse: Rita, I'd like to get a little information about your family history. Is there any history of high blood pressure in your family?

Rita: Not that I know of… Oh wait a minute – I think my aunt has it.

Nurse: But not your parents or siblings?

Rita: No, definitely not.

Nurse: OK. What about heart disease?

Rita: I think it runs in my family. Both my father and his father had it, and my older brother has it now.

Nurse: No one on your mother's side?

Rita: No.

Nurse: What about diabetes?

Rita: My sister Sami has it.

Nurse: Any family history of cancer?

Rita: Yes. My mother and her sister both had breast cancer.

Nurse: OK. Now let's talk about your personal history…

Medical Family History

Ask your classmate.

Does anyone in your family have…?

Condition	**Any Family History?**	**Family member with condition (mother, father, sister, brother, grandmother, grandfather)**
High blood pressure		
Heart disease		
Diabetes		
Cancer		

Medical Vocabulary

1. **Circle the words that are new for you.**
2. **Find the translation in your dictionary, or ask a classmate who speaks your language.**

English	My Language
Allergies	
Anemia	
Anxiety	
Blood	
Cancer	
Chicken Pox	
Cholesterol	
Depression	
Diabetes	
Diarrhea	
Dizziness	
Fatigue	
Heart Disease	
Hepatitis	
Kidney	
Mammogram	
Measles	
Memory	
Prostate surgery	
Tetanus	
Tuberculosis	
Vision	

Medical History

_______________________________ _______________
Name *Date of Birth*

_______________________________ _______________
Address *Phone number*

Single ❑ Partner/Married ❑ Divorced ❑ Widowed ❑

Do you have children? Ages of children (under 21) ______________________

How is your health? Excellent ❑ Good ❑ Fair ❑ Poor ❑

What is the reason for your visit today?

Are there any other reasons?

Do you have any ALLERGIES or REACTIONS TO MEDICINES? (Please list.)

Check the **immunizations** you have had:

❑ Hepatitis A Date _________
❑ Influenza (flu shot) Date_________
❑ Rubella Date _________
❑ Varicella (chicken pox) Date _________
❑ Hepatitis B Date _________
❑ Measles Date _________
❑ Tetanus (Td) Date _________

HEALTH SCREENING TESTS:

Cholesterol Date _________ Normal? Yes ❑ No ❑ Don't Know ❑

Colonoscopy Date__________ Normal? Yes ❑ No ❑ Don't Know ❑

Women: Mammogram Date ______ Normal? Yes ❑ No ❑ Don't Know ❑

Pap Smear Date____________ Normal? Yes ❑ No ❑ Don't Know ❑

Men: PSA (Prostate) Date_______Normal? Yes ❑ No ❑ Don't Know ❑

Please check any symptoms you have now or in the past.

	Past	Now
Fevers/Sweats		
Abdominal (stomach) Pain		
Allergies		
Anemia		
Anxiety/Stress		
Blood in Bowel Movement		
Cancer		
Cough		
Dizziness		
Depression		
Diabetes		
Diarrhea		
Eyes (vision problems)		
Fatigue		
Headaches		
Hearing Problems		
Heart Disease		
Heart Problems (chest pain, palpitations, other)		
High Blood Pressure		
High Cholesterol		
Kidney Problem		
Memory Loss		
Rash		
Sleep Problem		
Tuberculosis		
Vomiting		
Weight Loss or Gain		

What medications do you take? (Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs)

SURGERY (OPERATIONS): Please list all operations (surgery) with dates.

FAMILY HISTORY

	Family Member (brother, sister, mother, father, grandparent)
Cancer (include type – for example: colon, breast, etc.)	
High Blood Pressure	
Heart Disease	
Diabetes	

SMOKING

Cigarettes: Never ❑ Quit Date:____________________

❑ Current Smoker: Packs/day_____ No. of years_____

Other Tobacco: Pipe ❑ Cigar ❑ Snuff ❑ Chew ❑

ALCOHOL

Do you drink alcohol? No ❑ Yes ❑ How many drinks per week?_________

DRUGS

Do you use any recreational drugs? No ❑ Yes ❑

Have you ever used needles to inject drugs? No ❑ Yes ❑

CAFFEINE	How many cups per day?
Coffee	
Tea	
Soda	

DIET: How is your diet?

Good ❑ Fair ❑ Poor ❑

EXERCISE: Do you exercise regularly? No ❑ Yes ❑

SAFETY

Do you use a bike helmet? No ❑ Yes ❑ NA ❑

Do you use seatbelts in the car? No ❑ Yes ❑ NA ❑

Is VIOLENCE at home a concern for you? No ❑ Yes ❑

Have you ever been ABUSED? No ❑ Yes ❑

Do you have a GUN in your home? No ❑ Yes ❑

Adapted from http://www.pamf.org/forms/143952_Adult_Med_Hx.pdf

Dear New Patient:

Welcome to the Healthways Allergy Clinic.

In _____________ for your upcoming visit, please fill out the ________________ forms. This will help us to get a more complete _______________ of your health.

Please be sure to bring with you any ___________________ that you are currently taking.

If you need any _________________ completing the forms, please call our office during the hours ___________________.

Should you be unable to keep your appointment, please ___________ us at least 24 hours in advance.

Sincerely,

Carla Potter
Healthways Patient Coordinator