PERSONAL MEDICAL HISTORY

Student/Class Goal
Switching doctors can be an overwhelming issue for some adults, especially when they are asked to complete a personal medical history form. Having their medical histories may also help them better understand and gain control of their own health.

Outcome (*lesson objective)*
Students will gather the needed information and complete a personal medical history form that will aid in future medical experiences.

Time Frame
1-2 hours

Standard *Convey Ideas in Writing*

NRS EFL 2-4

COPS	**Activity Addresses Components of Performance**
Determine the purpose for communicating.	Students will write their medical histories to prepare for interactions with health services.
Organize and present information to serve the purpose, context, and audience.	Students will use suggestions from a guide to writing medical histories to organize their information. They will also fill out a medical history form.
Pay attention to the conventions of the English language usage, including grammar, spelling, and sentence structure to minimize barriers to readers' comprehension.	Students will choose which benchmarks to focus on during writing. The teacher will ask them to also focus on spelling.
Seek feedback and revise to enhance the effectiveness of communication	Students will peer edit each others' medical histories using a rubric.

Materials
Students will gather the needed information and complete a personal medical history form that will aid in future medical experiences.

Learner Prior Knowledge
Students will be familiar with seeking health care and may have been asked for their medical histories in the past. If necessary, students and teacher can discuss what kinds of information might be needed for a medical history. Often illnesses and diseases are difficult to pronounce and write; the teacher might want to work on this specific vocabulary with students. Students will have been introduced to the writing standard and will have used the standard to guide previous writing activities.

Instructional Activities
Step 1 - Have the students begin the lesson by discussing why writing down their personal medical history might be a good idea. List reasons on board or flip chart.

Step 2 **-** Before students begin working on rough drafts of their medical histories, have them identify which of the writing benchmarks they would like to focus on.

-- Use grammatical structures
-- Write sentences using sentence patterns needed for the writing situation
-- Use correct punctuation
-- Spell high frequency words
-- Use correct capitalization

Introduce the *Personal Medical History* Rubric to students at this time, explaining that the major focus for this lesson will be the component of performance that addresses the conventions of language usage. Explain how the other components will be addressed as they complete various activities during the lesson. A simple checklist could also be developed that highlights these skills.

Step 3 - Students begin working on rough drafts of their medical histories including specific illnesses, hospitalizations, surgeries, loss of work, injuries, accidents, medication used, and anything else that seems significant. They can do this in a timeline format or in narrative form. When students have written as much as they remember, have them brainstorm possible sources to aid in their medical history (doctor's office, family, clinic, ER).

Step 4 - Students should be given a few days to contact these resources for information to complete their medical histories. Begin to organize all this information into a format similar to what medical practitioners are most familiar. Try to be as accurate and detailed as possible. Use the *Personal Medical History Questions* handout to guide their writing.

TEACHER NOTE This form might be too long and complex to complete at one time, you may need to break it into parts or create a checklist or chart for the information. These questions can be found online at How to Write a Personal Medical History Form.

Step 5 - Once students have a more complete draft of their medical histories, they can peer-edit using the *Personal Medical History* Rubric. If privacy is an issue for students, peer editing can be eliminated and teacher can edit. Students can then revise their medical histories to correct any errors. Want to add a teacher note about how to handle sensitive medical information?

They will want to take a copy of this personal medical history with them when they visit a health facility and should keep a paper or computer copy on file at home.

Step 6 - To check for understanding and completeness, have the students practice filling out a sample medical history form.

TEACHER NOTE See McKinley Health Center Forms as their guide or use any of these online resources. Teachers may want to acquire actual forms from their local practitioners as well. Report of Medical History, Volleyball Medical History and Release Form, Adult Family Medical History, or UCI Medical Center Patient Health Survey provides several examples.

Step 7- Students can use their journals to write a 2-3-paragraph response explaining what they discovered about their medical past and what they should be aware of in the future.

Assessment/Evidence (*based on outcome)*
Personal Medical History Questions
Personal Medical History Rubric
Personal Medical History Form
Journal Reflection

Teacher Reflection/Lesson Evaluation
Not yet completed.

Next Steps

Technology Integration
How to Write a Personal Medical History Form http://www.essortment.com/write-personal-medical-history-form-34558.html
McKinley Health Center Forms http://www.mckinley.illinois.edu/forms/forms.htm
Report of Medical History http://www.dtic.mil/whs/directives/infomgt/forms/eforms/dd2807-1.pdf
Volleyball Medical History and Release Form http://www.scvavolleyball.org/documents/MedicalHistory_001.pdf
Adult Family Medical History http://www.ama-assn.org/resources/doc/genetics/adult_history.pdf
UCI Medical Center Patient Health Survey https://www.healthcare.uci.edu/pdfs/PatientHistoryEnglish.pdf

Purposeful/Transparent
The teacher is providing a template as a resource for students to gather the necessary information needed to complete a form.

Contextual
Students are often confronted with unknown medical language and will need to complete a medical history form when they go to the doctor. Having this information readily available in written form can help them with this task.

Building Expertise
Students are choosing which conventions of grammar they need to practice and are evaluated by their peers on these skills.

Personal Medical History Questions

1. Name, gender, birth date, marital status, religion

2. Spouse name, emergency contact person, health proxy, children's names and birthdates

3. Address, home phone, work phone, email, fax

4. Insurance company and number

5. Names and phone numbers of significant and recent practitioners seen – primary care doctor, specialists chiropractor, pharmacist

6. Present medical conditions – for example, diabetes, high blood pressure, hay fever, and other conditions that are current or chronic in nature; diseases and illnesses that affect your body often or always

7. Current medications – correct names, doses, when taken, when began, who prescribed, side effects, over-the-counter products, vitamins, herb, etc.

8. Allergies – to medications, foods, chemicals, natural and man-made substances, insects, and anything that causes an unusual reaction to your body; note how you respond to it

9. Past medical history – childhood illnesses, immunization history, pregnancies, significant short term illnesses, longer term conditions and other diseases that affected you in the past and are not mentioned previously

10. Hospitalizations – include in-patient stays, ER visits

11. Surgeries – minor and major, with anesthesia, out-patient, deliveries, invasive procedures, etc.

12. Significant and recent blood tests – most doctors will give you a copy of any blood work that is done; record only the significant values and file lab records. The important numbers to include: glucose (sugar), fasting cholesterol, while blood cell count, cancer values, kidney function, and other that your practitioner would need

13. Special tests and procedures – examples include x-rays and other radiology tests, EKG, stress test, echocardiogram, colonoscopy, or other similar procedures

14. Family history – limit it to the significant disease of your grandparents, parents, siblings, and children

15. Injuries, accidents, disabilities – what happened and what was done; how it has and does affect you now

16. Review of systems – this is a catch-all section for any problems you may be having or have had in the recent past. Under each of the following body systems, note any problems, symptoms and signs you experience, recent sicknesses, and other aspects that relate to that particular part of the body:

    a. Neurological – brain, nerves, headache

    b. Eyes – glasses, vision test results

    c. Ears – hearing, infections

    d. Nose, Sinus

    e. Throat

    f. Neck

    g. Lungs (respiratory)

    h. Heart (cardiac and vascular)

    i. Gastrointestinal - esophagus, stomach, intestines, rectum, liver, gallbladder, pancreas

    j. Urinary – kidney, bladder

    k. Sexual organs – STDs, recently activity and problems, drive

    l. Musculoskeletal – spine, bones, joints, muscles

m. Endocrine – glands, hormones, thyroid, diabetic symptoms

n. Blood and lymph glands – anemia, iron deficiency

o. Psychological – depression, anxiety, adverse attitudes, mood swings

p. General – fatigue, weakness, memory loss, confusion, weight changes, appetite, pain

17. Social history and lifestyle – habits, diet, exercise, sports, hobbies, household situation, frequent activities, significant relationships

18. Work history – current jobs, recent and significant, past occupations; particularly if you endured special work hazards, risks, stress, and other factors that affected your health

19. Chronological list of significant practitioner office visits in the past year or two

Personal Medical History Rubric

This rubric covers all the topics for the standard *Convey Ideas in Writing*. You will see that the italicized words in the chart are the same across the levels. The only differences in this standard are found in the conventions of language usage bold, red middle section. Please give the writer feedback in these areas.

	Level 2	**Level 3**	**Level 4**
Choose topic, purpose, and audience	*Personal Medical History* Forms	*Personal Medical History* Forms	*Personal Medical History* Forms
Generate Ideas	*Personal Medical History Questions* Handout	*Personal Medical History Questions* Handout	*Personal Medical History Questions* Handout

In the next 5 categories, check which column applies to the current skills/abilities of the writer. Highlight any benchmarks that need to be improved.

	Level 2	Level 3	Level 4
Grammatical Structures	Verb tenses, subject-verb agreement, noun-pronoun agreement 2.17	Pronoun usage 3.17	Clauses, phrases, placement of modifiers 4.18
Sentence Structure	Simple sentences (statements, questions, commands) 2.13	Simple/compound sentences 3.13	Simple/compound/complex sentences based on writing situation 4.14
Punctuation	End marks, commas in series and apostrophes in contractions/possessives 2.15	Commas, end marks, apostrophes, parentheses, quotation marks 3.15	Semicolons, colons, hyphens, dashes, brackets 4.16
Spelling	Correct spelling for multi-syllabic words, common root words, base words, affixes 2.14	Correct spelling for contractions, compounds, homonyms, irregular patterns 3.14	Correct spelling consistently 4.15
Capitalization	Proper nouns, titles, places, abbreviations 2.16	Correct capitalization based on writing situation 3.16	Correct capitalization 4.17
Feedback	*Personal Medical History* Rubric	*Personal Medical History* Rubric	*Personal Medical History* Rubric

Comments

Writer's Name _____ Editor's Name _____ Date _____