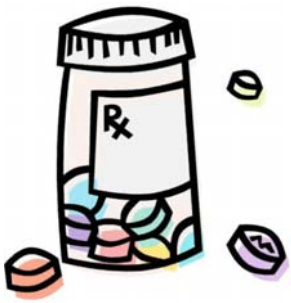

Health

INTRODUCTION

Before tutors and students can begin planning lessons, goals need to be set according to those expressed by the student and his/her existing level of English. Once the goals have been set (to gain employment, to be able to shop independently, to be able to communicate with their children's teachers, etc.) then the planning can begin.

This packet (1 of 10) has been developed to assist tutors in creating lessons that will help students in a practical manner in their every-day life. Life skills are listed under each topic or subject with ideas for practice activities. The use of real-life material, e.g. actual application forms, the telephone directory, the newspaper, in the lesson provides the student an opportunity to practice in a safe, non-threatening environment. Some examples of real-life material are included.

To give the tutor and the student satisfaction that progress is being made toward the goals, an **Achievement Log** has been developed. The log is for the recording by the student of those accomplishments achieved beyond and outside the lesson time. It might be that your student can now make phone calls, help a child with homework, write a note or fill out an application form. An awareness of these changes will motivate your student to set the next goals.

Materials for These Techniques

Newspaper/Magazine Ads
Catalogs
Telephone Directories
Forms
Over-the-counter Medication
3 by 5 Index Cards
Colored Markers
Post-It Notes
Prescription Bottles

HEALTH

Here are some life skills that can be used as the basis for a lesson with suggestions for practice activities.

1. Identify and speak the body parts.

   Suggestions: Together practice asking and answering questions, e.g. Where is your ear? This is my ear.

2. Find the telephone numbers of a local hospital, a doctor, a dentist, an eye doctor in the phone book.

   Suggestions: Write the numbers on a card to be kept near the telephone.

3. Make an appointment to see a doctor, a dentist, or an eye doctor.

   Suggestions: Discuss what information needs to be used in a telephone call to make an appointment. Together practice the phone call.

4. Call 911 in an emergency.

   Suggestions: Discuss when emergency calls should be made. Discuss the vocabulary that would be used in making the call. Practice the call.

5. Complete a variety of medical history forms.

   Suggestions: Select those words that the learner needs to be able to read, e.g. new patient, insurance, marital status. Make a list of the words. Look for the words on different medical forms.

6. Explain medical symptoms, e.g. My shoulder is sore. I have a pain in my chest.

   Suggestions: Make a list of common medical ailments. Together practice telling a doctor about the medical problem. (See page 8 for a crossword puzzle on symptoms).

7. Understand simple diagnostic/medical terms, e.g. blood pressure, temperature, pneumonia, infection.

   Suggestions: Make a list of simple medical terms. Discuss them.

8. Apply for medical insurance.

   Suggestions: Collect the necessary forms. Discuss the different options available. Fill out the forms.

9. Understand and complete medical claim forms.

   Suggestions: Read and discuss the information. Fill out the forms.

10. Explore and understand free medical resources. (See page ?)

11. Request medical records.

    Suggestions: Discuss when this might be necessary. Practice writing a note or making a telephone call to request records. Follow and understand emergency room procedures/forms.

12. Follow and understand emergency room procedures/forms.

    Suggestions: Visit an emergency room. Note signs and forms that have to be filled out.

13. Find a pharmacist.

    Suggestions: Use the yellow pages in the phone book to find a convenient pharmacist. Locate the pharmacy on a map.

14. Find over-the-counter medicines in a pharmacy.

    Suggestions: Make a collection of packages of over-the-counter products. Discuss them. Visit a pharmacy and look for a variety of medicines.

15. Read and understand directions for over-the-counter medications.

    Suggestions: Examine the directions on a variety of products. Study the words that are most relevant.

16. Fill and refill prescriptions.

    Suggestions: Discuss the procedure for renewing medicine in various ways, e. g, over the phone, in person, using the mail.

17. Read and understand instructions for prescription medications.

    Suggestions: Examine labels on a variety of medications. Discuss terms, e.g. twice a day, every four hours, take with meals.

18. Understand the schedule for childhood immunization shots and where to have them done.

    Suggestions: Discuss where this information can be found. Find the locations on a map.

19. Know how to convert Celsius temperatures to Fahrenheit. (See conversion chart on page ?).

    Suggestions: Practice converting temperatures.

20. Know how to convert centimeters and kilograms to pounds, feet, and inches. (See conversation scale in the back of this packet).

    Suggestions: Practice converting height and weight measurements.

21. Know how to read a doctor's appointment card.

    Suggestions: Obtain an appointment card. Discuss how the date and time is listed. Practice converting the time from military time (24-hour clock) to American time. Discuss how to cancel an appointment.

22. Know how to find medical resources.

    Suggestions: Discuss where to locate medical information, e.g., library, Internet, pamphlets in doctor's offices, hospital referral services, etc.

Activities for Building Vocabulary

Scavenger/Treasure Hunt: Make a list of words relating to the topic being studied, e.g. food, furniture, dictionary terms, etc. and ask the student to find them as you follow along, or if feasible, bring the objects to you. Variation: Say the word and ask the student to write the word on a Post-It Note and attach it to the located object.

Scrabble Game. Distribute the Scrabble tiles as directed by the game. Ask the student to spell out any word he/she can with these pieces. Play and score as in regular Scrabble as you and the student compete for points. Variation: Have student throw a die to determine how many tiles can be picked from all the tiles on the table and used to form words.

Reading Numbers. Create a deck of cards consisting of one digit on each card. Shuffle and lay down three cards, for example 352, and read the number aloud. Ask student to place one card next to any of the three digits and then read aloud the resulting number. For example, placing a 4 next to the first card results in "four hundred fifty-two." Placing a 4 next to the second card results in "three thousand four hundred fifty-two." Variation: Place a dollar sign to the left and include a decimal. [1]

Board Game. Trace around a quarter to form a series of circles across the top, bottom, and both sides of a sheet of paper. Write a vocabulary word inside each circle. Ask student to roll a die and move his/her marker (button or penny) that many spaces and then say a sentence using the word on which he/she landed. Variation: Play the same way but student asks a question using the word landed on.[2]

Dictation. Select or compose a short story or passage containing vocabulary words studied. Dictate the story. Provide the student with a printed version of the story with lines representing words omitted. Ask the student to listen to the story and write in the missing words on the lines provided as the dictation is given. Gauge the number of missing words according to the ability of the student—provide a small number for beginners and a larger number for more advanced students. Variation: Record the story on a tape so the student can do it as homework and can listen to the tape as often as needed.

Strip Story. For beginning students, write each sentence that makes up a short story on strips of paper. For more advanced students write the main events that make up a story on strips of paper, one event to each strip. Read the story to the student or ask the student to read it. Ask the student to arrange the strips of paper in the proper order of the story.

Concentration. Write matching pairs of vocabulary words on cards, e.g. holidays and the dates, antonyms, synonyms, idioms, etc. Place the cards face down on the table. Student turns over one card and tries to find the matching card. If cards match, they are left on the table face up. If cards do not match, both cards are turned over and two more cards are selected. Game continues until all cards have been turned over. Variation: Play this game with two or more students.

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[1] Source: Hands-on English, Vol. 11, No. 1, May/June, 2001.
[2] Source: Hands-on English, Vol. 12, No. 5, January/February, 2003.

Create Your Own Wordsearch

Name:_____ **Date:**_____

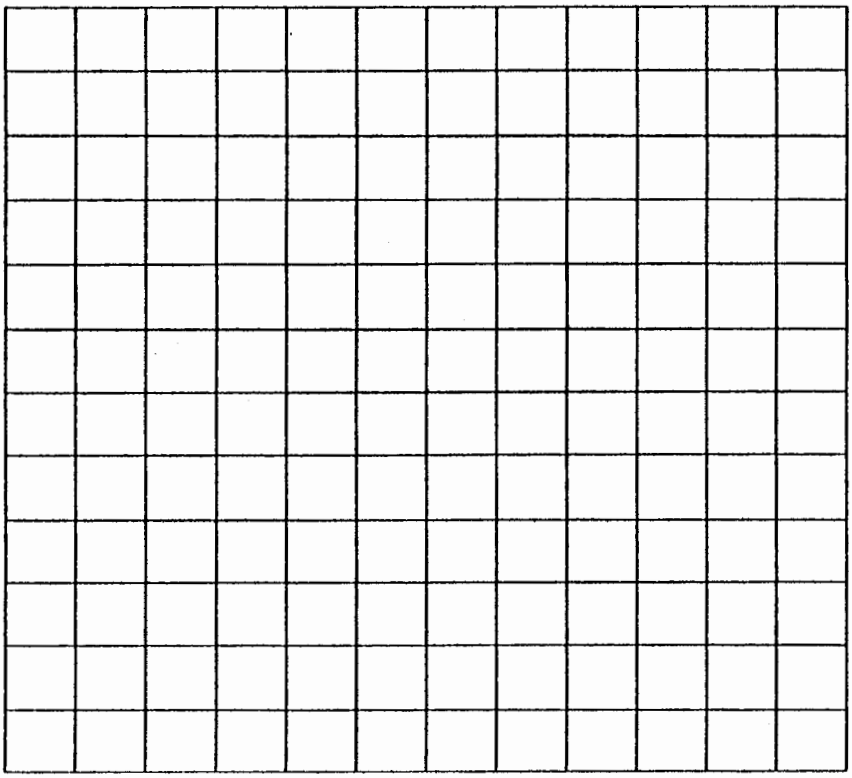
X	Y	P	A	I	N	P	N	A	R	M	O
D	E	N	T	I	S	T	A	D	F	G	H
L	E	Y	E	M	O	H	E	A	D	Q	S
N	U	R	S	E	T	L	U	N	G	S	U
Y	X	E	A	R	Y	W	Z	S	L	E	G
T	H	E	A	R	T	O	C	O	U	G	H
C	H	E	S	T	A	D	O	C	T	O	R
B	D	A	H	O	S	P	I	T	A	L	S
E	M	E	R	G	E	N	C	Y	L	M	N
D	S	B	L	O	O	D	P	S	H	O	T
X	T	E	M	P	E	R	A	T	U	R	E
S	O	R	E	D	T	H	R	O	A	T	M

Words:

✓ARM
LEG
HEAD
LUNGS
HEART
PAIN
DENTIST
DOCTOR
BLOOD
TEMPERATURE
HOSPITAL
NURSE
EYE
EAR
EMERGENCY
CHEST
SORE THROAT
COUGH
SHOT

Create Your Own Wordsearch

Name:_____ **Date:**_____



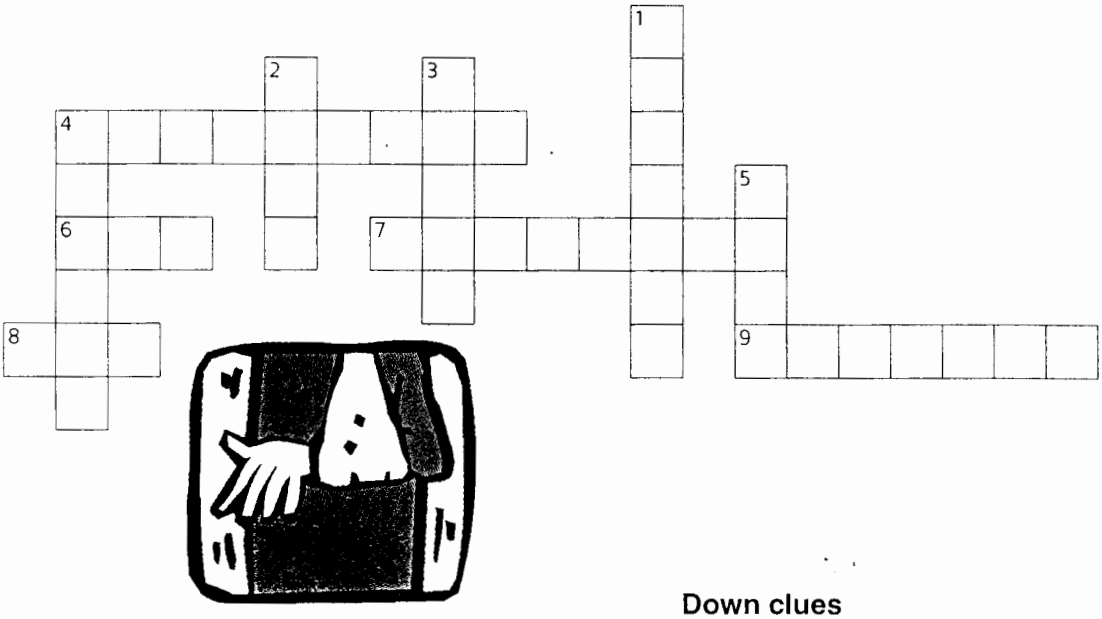
Words:

Multi-level crossword puzzle:
What are your symptoms?

Symptoms—Level A

Word list

cut
dentist
difficult
doctor
head
hot
medicine
outside
sick
sleep



Across clues

4. My father has arthritis. His back and his knees hurt. He has aching joints. It's _____ for him to move. Sometimes the pain is bad. He says it's because he's getting old.

6. "On Saturday my daughter fell down and _____ her chin." "What did you do?" "I was worried because it was bleeding a lot, so I took her to the emergency room." "Did she need stitches?" "No, the doctor said it would heal okay with a special bandage."

7. "My husband can't sleep at night. He coughs all night. His chest is congested and it hurts when he breathes." "Maybe he should go to the doctor." "We went to the doctor today. They took an X-ray, and they said his lungs look okay. The doctor said he has bronchitis. He's taking some _____ now." "I hope he feels better soon."

8. Husband: "Are you still feeling sick? Your head feels _____ . Maybe you have a fever."
Wife: "I just took my temperature. The thermometer says 99 degrees Fahrenheit, so it's almost normal."
Husband: I think you should rest today. I will cook dinner for you."

9. "I'm worried about one of my teeth." "Do you have a toothache?" "Not really, but it hurts when I eat or drink something very cold. That tooth is really sensitive to cold." "Maybe you have a cavity. You should see the _____ ."

Down clues

1. My friend Abbie has very bad allergies. In the winter she is fine. But in the spring she sneezes when she goes _____ . Her eyes get red and itchy. Her nose is runny. She is allergic to tree pollen and other things. If she stays inside with the air conditioner on, the symptoms are better.

2. "My son says he feels very _____ to his stomach. He has been nauseous all day." "Has he been vomiting?" "No, he didn't throw up yet but he feels really sick." "You should check to see if his abdomen is tender. He might have appendicitis." "That's good advice, thanks."

3. "Last night I started getting a sore throat. It hurts when I talk or eat something. Today I feel worse. I think I'm coming down with a cold." "Are you coming to English class?" "No, I think I should go to bed. I'm very tired and I need to _____ ."

4. "I'm worried about my mother. She says she can't sleep at night." "Has she had insomnia before?" "No, this started just a few weeks ago. I told her to see the _____ but she doesn't want to go."

5. "Hi, I'd like to make an appointment with Dr. Mica." "Sure. And what is it about?" "I have bad headaches almost every day." "How long have you had them?" "About three weeks." "Where is the pain?" "Usually in the front of my _____ . My forehead hurts and sometimes my nose and cheekbones hurt." "Okay, we can give you an appointment on Friday."

KidCare and FamilyCare Application

Please print in ink or type. If more space is needed to answer any question, please attach an extra sheet.

Applicant's Last Name _____ First Name _____
(The applicant is usually the person filling out this form; a child's parent, guardian, or relative or a pregnant woman.)

Birth Date (month, day, year) _____ Social Security Number ***(optional)***_____

Address_____City_____ State___ Zip Code_____ County_____

Home Phone ( ) _____ Work Phone ( ) _____

If no phone, name a contact person: Name_____ Phone ( )_____

Language Preference of Applicant: ❑ English ❑ Spanish ❑ Other (Specify) _____

Race or Ethnic Group: *(This information is optional. It will not affect your eligibility.)*
❑ White ❑ Black ❑ Hispanic ❑ American Indian or Alaska Native ❑ Asian or Pacific Islander ❑ Other ____

Complete questions #1 through #11 for family members who want health benefits. This includes pregnant women, children 18 or younger, parents living with their children, or other relatives who are caring for children in place of their parents. (If you need more space, attach an extra sheet.)

	Person #1	Person #2	Person #3
1. Name (last, first)			
2. Sex	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female
3. Birth Date	month/day/year	month/day/year	month/day/year
4. Social Security Number (optional for pregnant women)			
5. Relationship to Applicant (son, daughter, self, spouse, etc.)			
6. Is this person an American Indian or Alaska Native?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
7. U.S. Citizen? If no, and the person has an alien registration number, write the number here and **attach proof.**	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
8. For anyone 18 or younger, write: a. Mother's full name b. Father's full name For all others, write N/A	a. b.	a. b.	a. b.
9. Has this person received medical care in the past 3 months that you want the State to pay for? If yes, which months?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
10. Is this person pregnant or has this person been pregnant in the last three months?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

	Person #1	Person #2	Person #3
11. Is this person covered by health or hospital insurance (including Medicare) now or in the last three months? If yes, complete the following.	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
a. Date Coverage Began (month/year)	a.	a.	a.
b. Has insurance ended? If yes, why? Date Coverage Ended (month/year)	b. ❑ Yes ❑ No	b. ❑ Yes ❑ No	b. ❑ Yes ❑ No
c. Insurance Company	c.	c.	c.
d. Name of Policyholder	d.	d.	d.
e. Policyholder's SSN (optional)	e.	e.	e.
f. Employer Name and Phone Number	f.	f.	f.
g. Policy Number and Group Number	g.	g.	g.

12. How many people live with you? _____ Only include yourself, your spouse, children applying for KidCare and their brothers and sisters 18 or younger. For anyone 18 or younger who is applying for KidCare, include their parents if they live with you.

13. Complete the information below for the people you counted in #12 above who are **not** applying for KidCare. Do not complete the information for yourself if you are the "Applicant" on page 1. (Attach an extra sheet if necessary.)

Name_____ Social Security Number (optional)_____

Birth Date (month/day/year) _____ Relationship to Applicant _____

Name_____ Social Security Number (optional) _____

Birth Date (month/day/year) _____ Relationship to Applicant _____

14. Is any adult, parent, stepparent, spouse or pregnant woman named on this form currently employed? ❑ Yes ❑ No
If yes, complete the following and **attach proof** for the last month (see page 4). Is anyone self-employed? ❑ Yes ❑No

Name of Person _____ Employer _____

Employer Address_____ Employer Phone _____

Number of Hours Worked Weekly_____ Amount Paid (including tips) before taxes $_____How Often Paid _____

Name of Person _____ Employer _____

Employer Address_____ Employer Phone_____

Number of Hours Worked Weekly_____Amount Paid (including tips) before taxes $_____How Often Paid_____

15. Does anyone named on this form GET money from any source other than employment (such as Social Security, child support, spousal support, rental property, unemployment benefits, pensions, trusts)? ❑ Yes ❑ No If yes, complete the following and **attach proof** for the last month (see page 4).

Name of Person_____ Source _____ Monthly Amount $_____

Name of Person_____ Source _____ Monthly Amount $_____

If income is from rental property, is the person receiving the income also the property manager? ❑ Yes ❑ No

16. Does anyone named on this form PAY child support or spousal support? ❑ Yes ❑ No If yes, complete the following and **attach proof** for the last month (see page 4).

Name of Person _____ Monthly Amount $_____

Name of Person _____ Monthly Amount $_____

17. Does anyone named on this form PAY for day care so they can work? ❑ Yes ❑ No If yes, complete the following and **attach proof** for the last month (see page 4).

Name of Child(ren) in Day Care_____ Name of Care Giver_____

Person Paying Day Care_____Monthly Amount $ _____

Relationship of Care Giver to Child (if any)_____

DuPage County Health Department

Consent for Uses and Disclosures

The DuPage County Health Department may use and disclose protected health information about you in order to carry out treatment, payment and health care operations.

You have reviewed a copy of our current Notice of Privacy Practices. The Notice of Privacy Practices provides you with a description of the uses and disclosures the Department may make. The provisions of these policies and procedures may be revised as necessary and you at any time may request updated copies from the Department's Privacy Officer. You have the right to review these policies and procedures prior to signing the consent.

You have the right to request that the Department restrict how your protected health information is used or disclosed to carry out treatment, payment or health care operations. The Department shall adhere to any restrictions agreed to.

You have the right to revoke this consent in writing at any time, except to the extent that the Department has already taken action based on the current consent.

By signing this form, you consent to the Department's use and disclosure of protected health information about you for treatment, payment and health care operations. You also confirm that you have not requested any restriction on the Department's use or disclosure of protected health information.

This consent is a condition of your treatment with the DuPage County Health Department. If you decide not to sign this consent, the Department may decline to treat you. If you are unable to complete and sign this consent for any reason please advise the Department immediately.

_____ _____

Signature of Client or Client's Legal Representative Date

_____

Print Client's Name

_____ _____

Name of Legal Representative (if applicable) Relationship to Client

_____

Witness

4/2003 Original copy to client record

DIET HISTORY - INFANT

PLEASE COMPLETE BOTH SIDES OF THIS FORM AND BRING TO YOUR BABY'S CLINIC APPOINTMENT

INFANTS NAME_____ DATE_____

1. Are you primarily BREASTFEEDING or BOTTLEFEEDING?_____

If breastfeeding, answer SECTION A.
If bottlefeeding, answer SECTION B.
If both, answer SECTIONS A & B.

A. BREASTFEEDING:
   2. How many times in 24 hours does your baby nurse?_____
   3. How long does the baby nurse at each breast?_____
   4. Does your baby ever take a bottle? YES NO
      If YES, what does your baby take from the bottle?_____
      How often does your baby take a bottle?_____
      Reason for giving formula_____
   5. Are your having any specific problems breastfeeding?
      _____
   6. When do you plan on weaning your infant?_____
   7. Are you taking prenatal or any other vitamins at this time?
      _____
   8. Are you having any problems with sore nipples?_____
   9. When the infant nurses, do you feel tingling?_____
      burning_____ full feeling_____ thirsty_____
      leaking on the other side_____ nothing _____
      other_____
   10. Who initiates end of feeding? you_____ infant_____

B. BOTTLEFEEDING:
   2. Did you ever breastfeed your baby? YES NO
      If YES, how long did you breastfeed?_____
      Why did you stop?_____
   3. What kind of formula does your baby take?_____
   4. How do you prepare it?_____
   5. How many times a day does your baby take a bottle?_____
   6. How many ounces of formula does your baby take per bottle?
      _____
   7. Does your baby take anything else from the bottle? YES NO
      If YES, what?_____

C. ALL INFANTS:
   8. Who usually feeds the baby?_____
   9. How would you describe your baby's appetite?
      GOOD FAIR POOR
   10. Are you happy with your baby's weight? YES NO
      If NO, why not?_____
   11. Has your baby ever had an allergy to food or formula?
      YES NO
      If YES, what?_____
   12. Does your baby take any vitamins? YES NO
      If YES, what kind?_____
   13. Does your baby have any problem with (please circle):

      DIARRHEA CONSTIPATION GAS VOMITING SPITTING-UP

14. Is a pacifier used? ___YES ___NO How much?_____

15. Is your infant taking other foods at this time? YES NO
if YES, circle foods your child eats/drinks:

infant cereal juice cow's milk strained fruits
strained meats cookies table foods strained vegetables
snack foods

16. Do you have any questions regarding nutrition or what foods to feed your baby? If YES, what are your concerns?

_____

_____

24 HOUR RECALL

Please write down everything that you baby eats the day before your Clinic appointment, including the time, amount, and how the food was prepared. Include all formula, foods and beverages the baby eats for a 24 hour period.

TIME	AMOUNT	FOOD ITEMS
EXAMPLE		
8:00	8 OUNCES	SMA

Is this how your infant usually eats? YES NO
If NO, please explain._____

_____

_____

Immunization Screening



Is your child well today?

_____

Has your child had any shots in the last 4 weeks?

_____

Does your child have any allergies to food or medications?

_____

Did your child ever have any problems with his/her shots?

_____

Does your child or anyone in your household have cancer, leukemia, AIDS, or take steroids, anti-cancer drugs or x-ray treatments?

_____

Has your child received any blood/plasma in the last year?

_____

Does your child have a personal or family history of seizures?

_____

For Females: Is it possible that you are pregnant or may become pregnant in the next month?

_____

Have you ever had a positive TB test?

_____

DuPage County
Health Department

DUPAGE COUNTY HEALTH DEPARTMENT

Vaccine Administration Record

PLEASE PRINT / Person to receive vaccine:

Name: _____ **Sex :** M F
Last First MI

Birthdate _____ **Age** _____ **Telephone Number** _____

Address _____
Street City State Zip Code

Social Security Number _____ **Public Aid Number** _____

I have read or have had explained to me the information on the information forms about the disease(s) and vaccine(s). I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) be given to the person named above.
I consent to disclosure/release of the immunization history of the above-named client with appropriate health and educational personnel/sources, in compliance with applicable statutes and regulations.

***Signature** _____ **Date** _____

Signature of person to receive the vaccine(s) or person authorized to make the request

Code	Dose #	Vaccine	Dose Amt.	VIS\consent given? (add VIS date)	Manufacturer & Lot #	Site	Time
721		DTAP	.5cc				
702		Td (7+)	.5cc				
705		IPV	.5cc				
707		HIB	.5cc				
749		HEPB(0-18)	.5cc				
720		HEPB(19+)	1.0cc				
743		HEPB (Employee/Fee)	1.0cc				
723		HEPB / HIB	.5cc				
708		MMR	.5cc				
722		VARICELLA (1-12)	1vial				
732		VARICELLA (13+)	1vial				
728		PNEUM CONJ	.5cc				
748		DTAP/HEPB/IPV	.5cc				
718		TB	.1cc	Risk: High Low			

Administered by _____ **ID No.** _____ **Date** _____

Comments: _____

RETURN DATE: _____

PATIENT NUMBER

PATIENT'S NAME _____
Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER

1. Physician's Name _____
   Address _____
   _____
2. Are you under a physician's care? ..... YES NO
   Since when _____ Why _____
3. When was your last complete physical exam? _____
4. Are you taking any medication? ..... YES NO
5. Do you routinely take health related substances? ..... YES NO
6. Are you allergic to any medications or substances? ..... YES NO
7. Do you have any other allergies? ..... YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ..... YES NO
9. Are you sensitive to any metals or latex? ..... YES NO
10. Are you pregnant or suspect you may be? ..... YES NO
11. Do you use any birth control medications? ..... YES NO
12. Have you ever been treated for or been told you might have a heart disease? YES NO
13. Do you have a pacemaker or an artificial heart valve implant? ..... YES NO
14. Have you ever had rheumatic fever? ..... YES NO
15. Are you aware of any heart murmurs? ..... YES NO
16. Do you have high or low blood pressure? ..... YES NO
17. Have you ever had a serious illness or major surgery? ..... YES NO
    If so, explain _____
18. Have you ever had radiation treatment, chemo treatment for a tumor, growth or other condition? ..... YES NO
19. Do you have inflammatory diseases, such as arthritis or rheumatism? ..... YES NO
20. Do you have any artificial joints/prosthesis? ..... YES NO
21. Do you have any blood disorders, such as anemia, leukemia, etc? ..... YES NO
22. Have you ever bled excessively after being cut or injured? ..... YES NO
23. Do you have any stomach problems? ..... YES NO
24. Do you have any kidney problems? ..... YES NO
25. Do you have any liver problems? ..... YES NO
26. Are you diabetic? ..... YES NO
27. Do you have asthma? ..... YES NO
28. Do you have epilepsy or seizure disorders? ..... YES NO
29. Do you or have you had venereal disease? ..... YES NO
30. Have you tested HIV positive? ..... YES NO
31. Do you have AIDS? ..... YES NO
32. Have you had or do you test positive for hepatitis? ..... YES NO
33. Do you or have you had T.B? ..... YES NO
34. Do you smoke, chew, use snuff or any other forms of tobacco? ..... YES NO
35. Do you consume alcoholic beverages? ..... YES NO
36. Do you habitually use controlled substances? ..... YES NO
37. Have you had psychiatric treatment? ..... YES NO
38. Do you have any disease, condition, or problem not listed? If so, explain _____
    _____
39. Is there anything else we should know about your health that we have not covered in this form?
    _____
40. Would you like to speak to the Doctor privately about any problem? ..... YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

Form 140MH

MEDICAL HISTORY

PATIENT NUMBER

PATIENT'S NAME _____
Last First Initial Date of Birth

1. Purpose of initial visit _____
2. Are you aware of a problem? _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. Previous dentist's name _____
   Address: _____ Tel. (____)
6. When was the last time your teeth were cleaned? _____

CIRCLE THE APPROPRIATE ANSWER

7. Have you made regular visits? ..... YES NO
   How often? _____
8. Were dental x-rays taken? ..... YES NO
9. Have you lost any teeth or have any teeth been removed? ..... YES NO
   Why? _____
10. Have they been replaced? ..... YES NO
11. How have they been replaced?
    a. Fixed bridge _____ Age _____
    b. Removable bridge _____ Age _____
    c. Denture _____ Age _____
12. Are you happy with the replacement? ..... YES NO
    If no, explain _____
13. Would you like to know about permanent replacements? ..... YES NO
14. Have you ever had any problems or complications with previous dental treatment? YES NO
    If yes, explain _____
15. Do you clench or grind your teeth? ..... YES NO
16. Does your jaw click or pop? ..... YES NO
17. Have you experienced any pain or soreness in the muscles or your face or around your ear? ..... YES NO
18. Do you have frequent headaches, neckaches or shoulder aches? ..... YES NO
19. Does food get caught between your teeth? ..... YES NO
20. Are any of your teeth sensitive to hot ____ cold ____ sweets ____ pressure ____
21. Do your gums bleed or hurt? ..... YES NO
    When? _____
22. How often do you brush your teeth? _____ When _____
23. Do you use dental floss? ..... YES NO
    How often? _____
24. Are any of your teeth loose, tipped or shifted? ..... YES NO
25. Are you happy with the appearance of your teeth; do you have any discolored teeth that bother you? ..... YES NO
26. How do you feel about your teeth in general? _____
27. Do you feel your breath is offensive at times? ..... YES NO
28. Have you ever had gum treatment or surgery? ..... YES NO
    What _____
    Where _____
    When _____
29. Have you had any orthodontic work? ..... YES NO
30. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____
31. Do you have any questions or concerns? ..... YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE..

PATIENT'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

Form No. 150DH

DENTAL HISTORY

Temperature Conversion Chart

Celsius	Fahrenheit
0 C	32.0 F
1 C	33.8 F
2 C	35.6 F
3 C	37.4 F
4 C	39.2 F
5 C	41.0 F
6 C	42.8 F
7 C	44.6 F
8 C	46.4 F
9 C	48.2 F
10 C	50.0 F
11 C	51.8 F
12 C	53.6 F
13 C	55.4 F
14 C	57.2 F
15 C	59.0 F
16 C	60.8 F
17 C	62.6 F
18 C	64.4 F
19 C	66.2 F
20 C	68.0 F
21 C	69.8 F
22 C	71.6 F
23 C	73.4 F
24 C	75.2 F
25 C	77.0 F
26 C	78.8 F
27 C	80.6 F
28 C	82.4 F
29 C	84.2 F
30 C	86.0 F

The equation for converting Fahrenheit to Celsius is:

((Degree F) – 32) x (5/9) = Degree C

The equation for converting Celsius to Fahrenheit is:

Degree F = (9/5) Degree C + 32

APPROXIMATE METRIC EQUIVALENTS BY LENGTH

U.S.	Metric
¼ inch	.6 centimeters
1 inch	2.5 centimeters
2 inches	5.08 centimeters
4 inches	10.16 centimeters
5 inches	13 centimeters
6 inches	15.24 centimeters
12 inches	30.48 centimeters
36 inches	91.44 centimeters

APPROXIMATE METRIC EQUIVALENTS BY WEIGHT

U.S.	Metric
¼ ounce	7 grams
½ ounce	14 grams
1 ounce	28 grams
1 ¼ ounces	35 grams
1 ½ ounces	40 grams
2 ½ ounces	70 grams
4 ounces	112 grams
5 ounces	140 grams
8 ounces	228 grams
10 ounces	280 grams
15 ounces	425 grams
16 ounces (1 pound)	454 grams

Metric	U.S.
1 gram	.035 ounce
50 grams	1.75 ounces
100 grams	3.5 ounces
250 grams	8.75 ounces
500 grams	1.1 pounds
1 kilogram	2.2 pounds

Example

ACHIEVEMENT LIST OF REAL LIFE SKILLS USING ENGLISH

Name of learner:_____ Date:_____

Name of tutor:_____

What have you achieved and what are you able to do now or do better in everyday life?	Listen	Speak	Read	Write
Make an appointment to see a doctor.	✓	✓		
Fill in a medical history form.			✓	✓
Explain simple medical problems.	✓	✓		

Check (✓) any changes/achievements:

	✓	Date
Received US Citizenship		
Registered to Vote or Voted for the first time		
Gained Employment		
Obtained Job Advancement		
Obtained GED		
Entered other Ed.or Voc.Program		

What do you still want to learn?

What do you want to be able to do?