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	
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 i**mmunizations** you have had:
❑ Hepatitis A Date _____ ❑Hepatitis B Date _____
❑Influenza (flu shot) Date _____ ❑ Measles Date _____)
❑ Rubella Date _____ ❑Tetanus (Td) Date _____
❑ Varicella (chicken pox) 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	ow
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 # 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

Name _____ Date _____

Directions: Listen to the patients telling the nurse their health history. Fill in the information you hear. The first one is done for you.

	Patient #1	**Patient 2**	**Patient 3**	**Patient 4**	**Patient 5**
Last Name	L-E-O-N-G			.	
Date of Birth	3-27-64.				
Surgery?	knee				
Allergies	penicillin				
Medication	For stomach				
Family History	----				
cancer	mother				
diabetes	no				
Heart disease	Sister, father				

A

1. You are the patient. Your partner will ask you some questions. Use this information for your answers.

Name	Birthdate	Surgery	Allergies	Family History
Lisa Wong	4-23-71	None	Dogs	Cancer: Mother Diabetes: None Heart Disease: Sister

2. You are the nurse.
Ask your partner these questions. Write the answers here.

Nurse: What's your name?
Patient:
Nurse: And your last name?
Patient:
Nurse: Could you spell that?
Patient:
Nurse: Date of birth?
Patient:
Nurse: Have you ever had any surgery?
Patient:
Nurse: When was that?
Patient:
Nurse: Any other surgeries?
Patient:
Nurse: Do you have any allergies?
Patient
Nurse: Are you taking any medication?
Patient:
Nurse: Any family history of cancer?
Patient:
Nurse: Any family history of diabetes?
Patient:
Nurse: Any family history of heart disease?
Patient:

B

1. You are the Nurse.
Ask your patient the questions. Write the answers:

Nurse: What's your name?
Patient:
Nurse: And your last name?
Patient:
Nurse: Could you spell that?
Patient:
Nurse: Date of birth?
Patient:
Nurse: Have you ever had any surgery?
Patient:
Nurse: Any other surgeries?
Patient:
Nurse: Do you have any allergies?
Patient:
Nurse: Are you taking any medication?
Patient:
Nurse: Any family history of cancer?
Patient:
Nurse: Any family history of diabetes?
Patient:
Nurse: Any family history of heart disease?
Patient:

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2. You are the patient. Your partner will ask you some questions.
Use this information for your answers.

Name	Birthdate	Surgery	Allergies	Family History
Luis Contreras	February 11, 1968	Heart surgery 2003	Dust Cats	Cancer: Uncle, Brother Diabetes: Mother Heart Disease: Sister