Directions: Provide students with a copy of this case history information. Read it aloud to them. As a class exercise, use this information to fill in Beth Jones' personal, medical, and dental information forms. Use this information and the Jones' Family Tree to fill out the Jones' family history chart.

Case History for Patient Health and Dental Forms

Elizabeth Jones
1955 W. Austin Ave.
Harris, IL 60799
Home Phone: (709) 356-0987
Social Security Number: 354-98-0021

Beth was born on February 27, 1975. She is 5'6" tall, has brown hair and brown eyes, and weighs 130 pounds. She is nearsighted and wears contact lenses or glasses.

She is married but doesn't have any children. Beth's husband, Joseph S. Jones, is 32. His social security number is 792-85-2134.

Beth enjoys playing volleyball and lifting weights two or three times a week. She smokes a pack a day. She drinks alcohol occasionally and considers herself a social drinker.

Beth is a delivery truck driver for UPS. She works out of a UPS center at 39 S. Oak, Springfield, IL 63987. She works full-time and she has health and dental insurance from her company. Her insurance information is below:

Health Insurance
Blue Cross and Blue Shield of Illinois PPO
Group Name: UPS
Group Number: 2343567
ID number is same as social security number

Dental Group Number: 2343567D
ID number is same as social security number

Beth's parents live near her. She usually uses her father as an emergency contact. Her father's name is Steven Jones, and his cell phone number is (983) 234-5677.

In general, Beth's health is pretty good, except that her cholesterol was high two years ago and now she watches her diet carefully. Her last checkup was in April 2006. At that time, she also had a Pap Smear. She has only stayed in the hospital once, in 1988 when she had her appendix removed. She doesn't take any medications except birth control pills—just cold medicine or aspirin once in awhile. She's never had an allergic reaction to a medication, but she is allergic to strawberries. She started menstruating at age 12. She doesn't have any other serious health problems right now.

Case History for Patient Health and Dental Forms, continued

Beth doesn't like going to the dentist. In fact, her last dental visit was four years ago. She brushes twice a day. Her teeth are sensitive to cold drinks, and sometimes her gums bleed when she brushes her teeth. She only flosses if she gets food caught between her teeth. Beth wore braces on her teeth in high school.

Beth's dad has high cholesterol, and so does Beth's brother. Since some health problems can run in families, Beth knows that it's important to give her doctor as much information as she can about health problems that her family members have. Beth's mother and sister both have anemia, and so did her grandmother when she was alive. Her grandmother also had colon cancer. There's arthritis on both sides of Beth's family—her mom has arthritis, and so does her dad's father. The same grandfather also has osteoporosis.

Patient Information Form

Directions: Your teacher will tell you about a patient. With your class, fill out this form with the patient's information.

1. Last name: _____

   First name: _____ Middle initial: _____

2. Street address: _____

   City: _____ State: _____

   Zip code: _____

3. Date of birth: _____
   (month, day, year)

4. Social Security Number: _____

5. Marital status -- put a check mark (√) on the correct blank:

   Single ____ Married ____ Divorced ____ Widowed ____

6. Occupation/job: _____

7. Employer's name: _____

8. Employer's street address: _____

   City: _____ State: _____

   Zip code: _____

Patient Information Form, continued

9. Last name of spouse: _____

   First name: _____ Middle initial: _____

10. Spouse's Social Security Number: _____

11. Insurance provider name: _____

12. Name of holder of this insurance plan: _____

13. Relationship to patient: _____

14. Insurance Group # _____ ID #: _____

15. Emergency phone number: _____

16. Name of emergency contact: _____

17. Relationship to patient: _____

Patient Medical History Form

Directions: Your teacher will tell you about a patient. With your class, fill out this form with the patient's information.

1. Date of last medical exam (month, year) _____

2. Have you ever been hospitalized for surgery or serious illness? Yes ___ No ___
If yes,

Date	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Are you taking any medications (prescriptions or over-the-counter) regularly?

Yes _____ No _____ If yes, what medications are you taking?

_____

_____

_____

_____

4. Do you wear glasses or contact lenses? Yes _____ No _____

5. Are you allergic to any medication or have you had any reactions?

Yes _____ No _____ If yes, fill out the chart below.

Name of Medication	Reaction	When

Patient Medical History Form, continued

6. Are you allergic to anything else (food, pollen, dust, etc.)? Yes ____ No _____

7. Do you have or have you had any of the following:

a.	arthritis	Yes _____	No _____
b.	diabetes	Yes _____	No _____
c.	hypertension/high blood pressure	Yes _____	No _____
d.	high cholesterol	Yes _____	No _____
e.	mental illness	Yes _____	No _____
f.	kidney disease	Yes _____	No _____
g.	osteoporosis	Yes _____	No _____
h.	sexual/physical abuse	Yes _____	No _____
i.	thyroid disease	Yes _____	No _____
j.	HIV/AIDS	Yes _____	No _____
k.	heart disease/heart attack	Yes _____	No _____
l.	substance abuse	Yes _____	No _____
m.	alcoholism	Yes _____	No _____
n.	asthma	Yes _____	No _____
o.	seizures	Yes _____	No _____
p.	stroke	Yes _____	No _____
q.	anemia/blood diseases	Yes _____	No _____
r.	liver diseases	Yes _____	No _____
s.	immune problems	Yes _____	No _____
t.	cancer	Yes _____	No _____
u.	frequently tired	Yes _____	No _____
v.	recent weight loss	Yes _____	No _____
w.	other:		

_____

_____

Patient Medical History Form, continued

8. For Women Only

pregnancies _____ # live births _____

Date of last Pap Smear _____ Date of last Mammogram _____

Age periods began _____ First day of last period _____

Do you use birth control? Yes _____ No _____

If yes, what kind? _____

Patient Dental Form

Directions: Your teacher will tell you about a patient. With your class, fill out this form with the patient's information.

1. Do your gums bleed while brushing or flossing? Yes ___ No ___

2. Are your teeth sensitive to hot or cold liquids/foods? Yes ___ No ___

3. Are your teeth sensitive to sweet or sour liquids/foods? Yes ___ No ___

4. Do you feel pain in any of your teeth? Yes ___ No ___

5. Do you have any sores or lumps in or near your mouth? Yes ___ No ___

6. Have you had any head, neck or jaw injuries? Yes ___ No ___

7. Have you ever experienced any of the following problems in your jaw:

    a. Clicking? Yes ___ No ___

    b. Pain (joint, ear, side of face)? Yes ___ No ___

    c. Difficulty in opening or closing? Yes ___ No ___

    d. Difficulty in chewing? Yes ___ No ___

8. Do you have headaches often? Yes ___ No ___

9. Do you clench or grind your teeth? Yes ___ No ___

10. Do you bite your lips or cheeks often? Yes ___ No ___

Patient Dental Form, continued

11.	Have you ever had any difficult extractions in the past?	Yes ___ No ___
12.	Have you had any orthodontic treatment?	Yes ___ No ___
13.	Have you ever had prolonged bleeding following extractions?	Yes ___ No ___
14.	Have you ever had instruction on the correct method of brushing your teeth?	Yes ___ No ___
15.	Have you ever had instructions on the care of your gums?	Yes ___ No ___