Instructor Page

Provide students with a copy of the following:

- Beth Jones' Case History
- Jones Family History Tree
- blank personal, medical, family history, and dental forms

Read the case history aloud with the class. Demonstrate how the case history information "maps" to the Jones Family History Tree. As a whole class exercise, use this information to fill in Beth Jones' personal, medical, family history, and dental information forms. When information is not known, leave the spaces blank.

Case History

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 2002. 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.

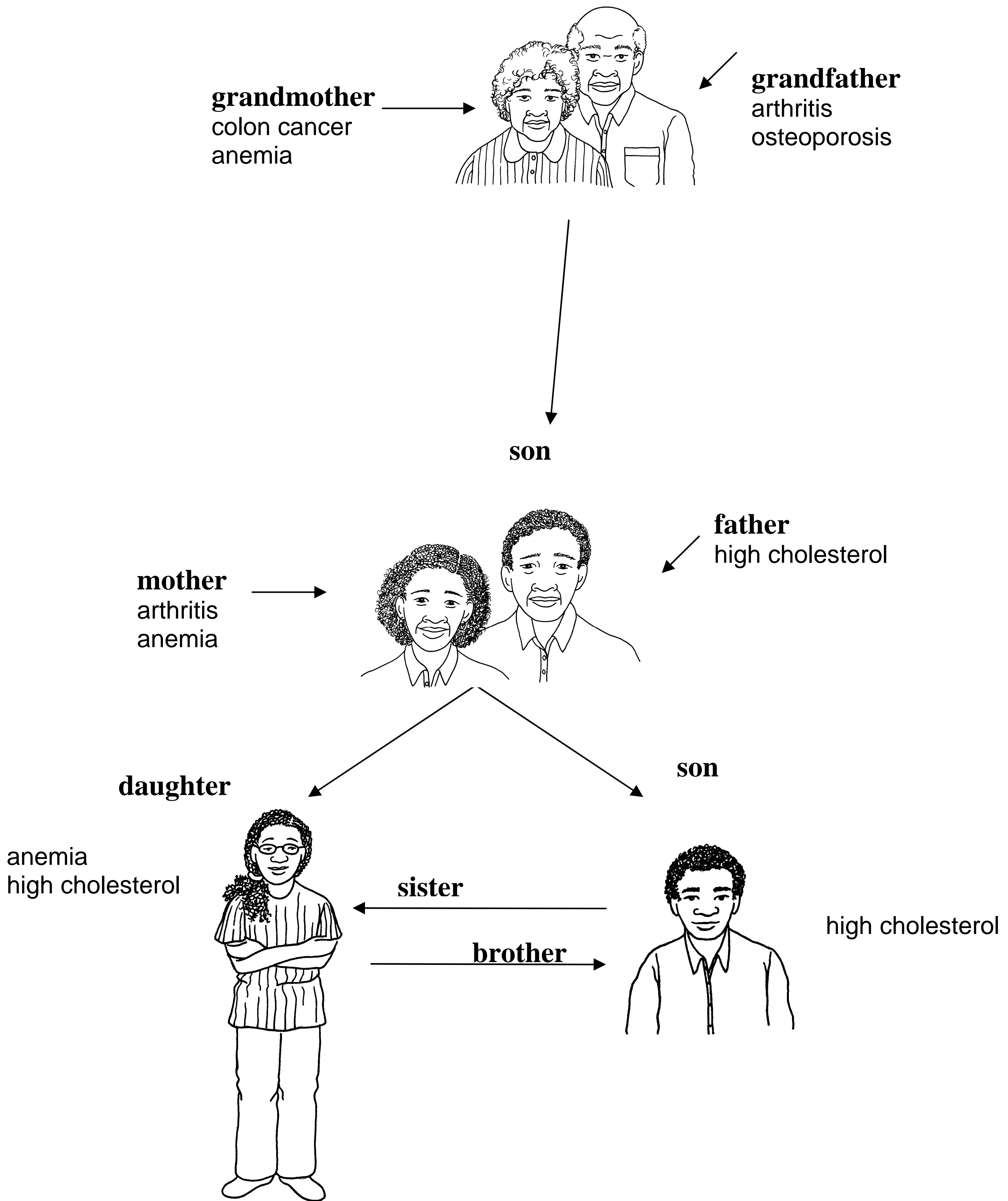
Case History for Patient Health Forms, continued

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. There's anemia on both sides of Beth's family - Beth's mother and sister have anemia, and so did her grandmother on her dad's side. 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.

Directions: Use Beth Jones' Case History and this Family History Tree to transfer the health condition information to the Jones Family Chart.

Jones Family History Tree



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 Family History Form

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

	Yes	**No**	**If yes, who? (e.g., father, mother, sibling, son, daughter, grandparent, etc.)**
arthritis			
diabetes			
hypertension/ high blood pressure			
high cholesterol			
mental illness			
kidney disease			
osteoporosis			
sexual/physical abuse			
thyroid disease			
HIV/AIDS			
heart disease/ heart attack			
substance abuse			

Patient Family History Form, continued

	Yes	No	If yes, who? (e.g., father, mother, sibling, son, daughter, grandparent, etc.)
alcoholism			
asthma			
seizures			
stroke			
anemia/blood disease			
liver diseases			
immune problems			
cancer - fill in the blank for type: ____________ ____________ ____________			
other disease - fill in the blank: ____________ ____________ ____________			

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 ___