Official Homo Sapiens Family Medical Records

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Official Homo Sapiens Family Medical Records

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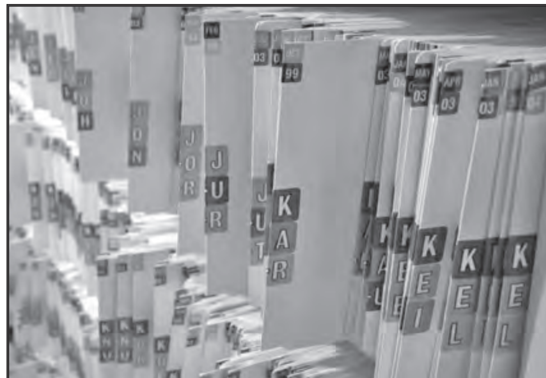

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Family Medical Records

Objective: Learners will learn to keep track of their family's medical history and will receive sample forms and information to help them do so.

The Importance of Keeping Medical Records

Worksheet: *None*

1. Ask learners why it's important to keep good health records. Answers could include *to know how well their bodies are working; to give correct information to their doctors; to provide an accurate health history for family members.*

2. Inform learners that when they go to a new doctor, they will have to update him on their past medical history. This includes any operations, illnesses, medications, or tests they have had. With this valuable information, he can get a good idea of how a patient's body is working and, in many cases, avoid unnecessary tests and guessing games that can take days, months, or even years.

My Family's History, Maintenance and Repair Records

Worksheet: *Page 16* **Learner's Workbook:** *Page 3*

1. Explain that learners will read the worksheets to help them keep track of their family's health history. Encourage them to take these home and share them with family members and friends.

2. Select a volunteer to read page 16, Learner's Workbook page 3. When he is finished reading, talk about the information together.

Diagnosing Your Medical Problems

Worksheet: *Pages 17-19* **Learner's Workbook:** *Pages 4-6*

Have a volunteer read page 17, Learner's Workbook page 4. Then have learners complete pages 18 and 19, Learner's Workbook pages 5 and 6. Suggest they share them with a doctor at their next check-up. Explain that this form will help him detect any medical problems and correct them before they become serious.

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Your Main Medical Problem

Worksheet: *Pages 20 and 21* **Learner's Workbook:** *Pages 7 and 8*

Review pages 20 and 21, Learner's Workbook pages 7 and 8, with learners. Let them complete the form and take a copy of it whenever they go for a check-up. They should go over the information with their doctor, since it's easy to forget certain medical conditions without taking detailed notes. Remind learners to keep the original in a safe place.

Repair Order

Worksheet: *Pages 22 and 23* **Learner's Workbook:** *Pages 9 and 10*

1. Discuss any frustrating experiences learners or their family have had with doctors.

2. Inform everyone to take pages 22 and 23, Learner's Workbook pages 9 and 10, with them the next time they visit the doctor. Remind them to ask any questions they may have at the office instead of waiting until they get home and having to leave a message.

Family History

Worksheet: *Page 24* **Learner's Workbook:** *Page 11*

1. Have learners share any medical conditions that run in their family. What will they do to try to avoid experiencing the same condition?

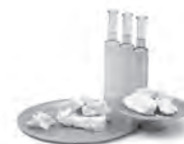
2. Explain how page 24, Learner's Workbook page 11, will allow learners to record and review any medical problems that occur in their family. For example, during pregnancy, it is important to know about any past medical conditions in the family so a doctor can test a patient for illness and keep a close eye on the unborn baby throughout the pregnancy.

3. Direct learners to bring this sheet home and speak to the family members listed at the top of the page. They should then check off any illnesses each relative may have had in his lifetime.

Worth Remembering...

"It is the mind that makes the body."

—Sojourner Truth



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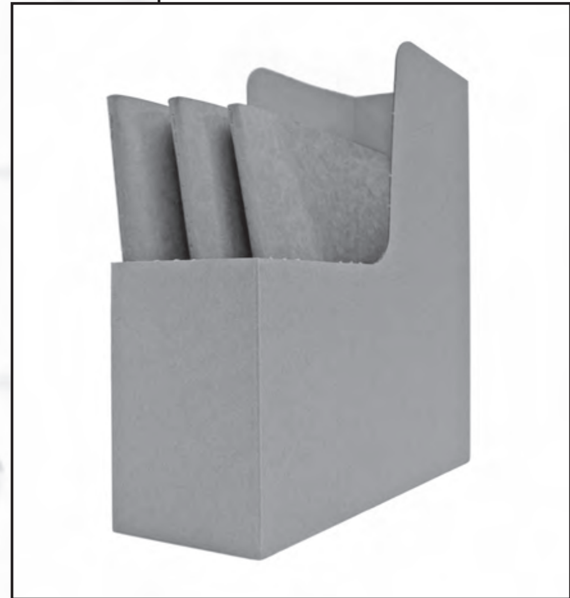
My Family's History, Maintenance, and Repair Records

The following forms are a goldmine of information, invaluable for diagnosing and treating many conditions. Take copies of these forms—not the originals—and your family history with you when you visit a physician or clinic for the first time. Make sure to keep the originals at home in a safe place.



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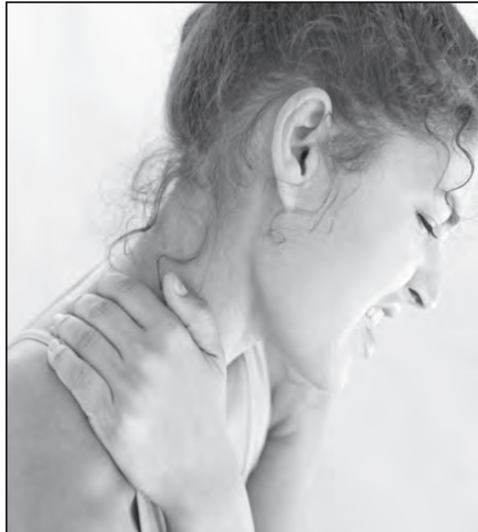
Diagnosing Your Medical Problems

Share this valuable information with your doctor. Please read the instructions carefully. The next page lists possible frequent medical symptoms. Please indicate:

1. How *often* you have the symptom, if at all (circle 0 to 8 on the scale).
2. The *degree of discomfort* caused by each symptom (select a number on a scale of 0 to 10).
3. The *degree of interference* caused by each symptom and how much it affects your daily activities (select a number on a scale of 0 to 10).

Write an answer for every symptom. If one *does not* apply to you, circle or write "0." For every symptom you *do* have, be sure to indicate the frequency, degree of discomfort, and degree of interference by using numbers 1 to 10.



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Diagnosing Your Medical Problems (cont.)

Complete a copy of this form before arriving at a doctor's office to help him understand your problem.

FREQUENCY									DEGREE OF DISCOMFORT	DEGREE OF INTERFERENCE
Circle the appropriate number.									Select a number: 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10	
SYMPTOMS	NEVER/ ALMOST NEVER	LESS THAN ONCE PER MONTH	ONCE TO TWICE PER MONTH	ONCE PER WEEK	TWO-THREE TIMES PER WEEK	FOUR-SIX TIMES PER WEEK	ONCE PER DAY	MORE THAN ONCE PER DAY	0: No discomfort 10: Extreme discomfort	0: No interference 10: Extremely interfering
1. Headache	1	2	3	4	5	6	7	8		
2. Blurred or double vision	1	2	3	4	5	6	7	8		
3. Dizziness/ fainting	1	2	3	4	5	6	7	8		
4. Numbness	1	2	3	4	5	6	7	8		
5. Ringing in ears	1	2	3	4	5	6	7	8		
6. Nausea	1	2	3	4	5	6	7	8		
7. Vomiting	1	2	3	4	5	6	7	8		
8. Constipation	1	2	3	4	5	6	7	8		
9. Loose stools	1	2	3	4	5	6	7	8		
10. Discomfort urinating (pressure, burning)	1	2	3	4	5	6	7	8		
11. Abdominal discomfort (non-menstrual cramps)	1	2	3	4	5	6	7	8		
12. Aching muscles	1	2	3	4	5	6	7	8		
13. Aching joints	1	2	3	4	5	6	7	8		
14. Aching back	1	2	3	4	5	6	7	8		

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Diagnosing Your Medical Problems (cont.)

Complete a copy of this form before arriving at a doctor's office to help him understand your problem.

FREQUENCY									DEGREE OF DISCOMFORT	DEGREE OF INTERFERENCE
Circle the appropriate number. SYMPTOMS	NEVER/ ALMOST NEVER	LESS THAN ONCE PER MONTH	ONCE TO TWICE PER MONTH	ONCE PER WEEK	TWO-THREE TIMES PER WEEK	FOUR-SIX TIMES PER WEEK	ONCE PER DAY	MORE THAN ONCE PER DAY	Select a number: 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 0: No discomfort 10: Extreme discomfort	0: No interference 10: Extremely interfering
15. Discomfort in limbs (aching, burning)	1	2	3	4	5	6	7	8		
16. Chest pain (burning, pressure, tightness)	1	2	3	4	5	6	7	8		
17. Palpitations	1	2	3	4	5	6	7	8		
18. Excessive sweating	1	2	3	4	5	6	7	8		
19. Shortness of breath	1	2	3	4	5	6	7	8		
20. Coughing	1	2	3	4	5	6	7	8		
21. Wheezing	1	2	3	4	5	6	7	8		
22. Skin problems (rash, itching)	1	2	3	4	5	6	7	8		
23. Teeth grinding	1	2	3	4	5	6	7	8		
24. Sleeping difficulties	1	2	3	4	5	6	7	8		
25. Fatigue	1	2	3	4	5	6	7	8		
26. Other: (be specific)	1	2	3	4	5	6	7	8		

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YOUR MAIN MEDICAL PROBLEM

Give a copy of this completed form and the one on pages 18 and 19 to your doctor as soon as you enter his office. Always keep the *originals* at home in a safe place.

Your Name: ________________________ Date:______________________

Describe your *main* medical problem: ____________________________________

____

Exact location of numbness, weakness, or pain: ____________________________

1. How long have you had this problem? _________________________________

2. Have you ever received medication for this problem? Yes No (circle one)

3. Are you being treated with medicines now? Yes No (circle one)

4. Please list below any medicines you are *currently* taking for this problem, including the frequency and dosage:

Name of Drug	Times per Day or Week	Dosage
____________________	____________________	______________
____________________	____________________	______________
____________________	____________________	______________

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Your Main Medical Problem (cont.)

5. List *any other* medicines you are taking on a *regular basis*, including birth control pills and all *nonprescription drugs*, such as aspirin, cough syrup, and antihistamines.

Name of Drug	Times per Day or Week	Dosage
____________________	____________________	______________
____________________	____________________	______________
____________________	____________________	______________

6. Have medicines prescribed for your main medical problem ever caused any side effects or problems? Yes No (circle one)

If yes, please describe the side effects: ________________________________

____

7. List other medical problem(s): ________________________________

____

8. Drugs you are allergic to: ________________________________

____

____

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Repair Order

Complete this repair order while you are still at the doctor's office. This is the perfect time and place to ask questions. Be clear on every detail. Your health depends on it. Above all, don't be intimidated! Take your time.

Name:	
Date:	Doctor's name:
Birth date: / /	Address:
Age:	City/State/Zip:
Sex (circle one): M F	Phone:
My health problems/ symptoms are:	Description of diagnosis/treatment:

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Repair Order (cont.)

Examination and lab test results

Weight:
Pulse:
Blood pressure
Systolic: Diastolic:
Urinalysis:
Electrocardiogram (EKG)
Blood sugar level:
Cholesterol level:
High-density lipoprotein:
CAT scan:
X-ray:
Culture:
Pap smear:
Mammogram:
Other: ______________________

Prescription Drugs

Read the instructions on the label before taking any medication. Report side effects to your doctor immediately.

Cost ($)

Doctor ___________
Laboratory ___________
Treatments ___________
Medication ___________
Vitamins, etc. ___________
Other ___________

TOTAL _______________

Important questions to ask your doctor about your prescription:

1. What is the drug supposed to do?
2. Why are you choosing this drug for me?
3. How and when should I take it? With meals? On an empty stomach? How often? At what times?
4. How long before I can expect improvement of my symptoms?
5. When should I stop taking it?
6. How many times can I fill the prescriptions?
7. Are there any foods, drinks or other medications I should avoid? Should I avoid driving, sun exposure or other activities?
8. Are there any side effects?
9. If someone accidentally takes my medicine or if I take too much, what should I do?
10. What if I become pregnant while taking the drug?
11. What should I do if treatment doesn't work?

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FAMILY HISTORY

Check the box if your relatives have had any of the medical problems listed here.	MOTHER	FATHER	SISTER	BROTHER	SISTER	BROTHER	MOTHER'S MOTHER	MOTHER'S FATHER	FATHER'S MOTHER	FATHER'S FATHER	MOTHER'S GRANDMOTHER	MOTHER'S GRANDFATHER	FATHER'S GRANDMOTHER	FATHER'S GRANDFATHER	OTHER
AIDS															
Alcoholism															
Allergies															
Anemia															
Cancer															
Depression															
Diabetes															
Drug use															
Emotional problems															
Headaches															
Hearing loss															
Heart disease															
Hypertension															
Kidney problems															
Mental disorder															
Obesity															
Pesticide exposure															
Psychosis															
Rheumatoid arthritis															
Stroke															
Tuberculosis															
Ulcer															
Age at death															
Year															

Cause of death (include person and explanation):

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