These 6 staying healthy goals will help prevent poor health and keep you and your family healthy. What will you do TODAY to reach these goals?

<table>
<thead>
<tr>
<th>Staying Healthy Goals</th>
<th>What will you do to reach this goal?</th>
</tr>
</thead>
</table>
| **1 Eat Healthy Food.** | □ Eat an apple.  
□ Try spinach.  
□ Use less sugar.  
□ ___________________ |
| **2 Keep a Healthy Weight.** | □ Ask your doctor what’s a healthy weight for you.  
□ Make a weight goal and ask family to help you reach it.  
□ ___________________ |
| **3 Exercise More.** | □ Walk at lunch time.  
□ Play with my kids.  
□ Take the stairs.  
□ ___________________ |
| **4 Don’t Smoke.** | □ If you smoke, don’t smoke inside.  
□ Help a friend quit smoking.  
□ Call 1-800-784-8664 for tips.  
□ ___________________ |
| **5 Get a Checkup.** | □ Find a primary care center.  
□ Make an appointment.  
□ Sign up for health insurance.  
□ ___________________ |
| **6 Take Care of Stress.** | □ Do something fun.  
□ Call a friend.  
□ Go for a walk.  
□ ___________________ |
Parts of the Body

- Head
- Shoulders
- Chest
- Stomach
- Arms
- Hands
- Feet
- Head
- Shoulders
- Back
- Arms
- Hands
- Feet
- Eyes
- Ears
- Mouth
- Nose
- Neck
cough

dizziness

fatigue

fever

sore throat

headache
itching

pain

sneezing

stomach ache
Speaking
Practice this dialogue with a partner.

Dialogue

Health Center: Hello, health center. How may I help you?
Patient: Hello, this is Fatima Tuma. I want to make an appointment.
Health Center: How do you spell your name?
Patient: T U M A
Health Center: What is the problem?
Patient: I have a headache and sore throat.
Health Center: Do you have a fever?
Patient: No, I don’t.
Health Center: Okay, come in tomorrow at 10 am.
Patient: Thank you.

Dialogue

Health Center: Hello, health center. How may I help you?
Patient: Hello, this is ______________. I want to make an appointment.
Health Center: How do you spell your name?
Patient: __________________.
Health Center: What is the problem?
Patient: I have ______________ and ______________.
Health Center: Do you have a fever?
Patient: ________________.
Health Center: Okay, come in ______________ at 10 am.
Patient: Thank you.
**Filling Out Forms at the Doctor's Office**

*Directions:* Listen to the dialogue. Then practice the dialogue with a partner.

Janet is having stomach problems. She made an appointment with Dr. Jonas. This is her first visit to Dr. Jonas' office.

**Receptionist:** Good morning.

**Janet:** Good morning. I have a 9 o'clock appointment.

**Receptionist:** Please sign in. Are you a new patient?

**Janet:** Yes.

**Receptionist:** Please fill out these forms and sign them at the bottom.

[a few minutes later...]

**Janet:** I don't understand this form. Can you please help me?

**Receptionist:** Sure.

**Janet:** Thank you.
Patient Information Form

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: ______________________________________
**Action**

Fill out this health history form. Use your dictionary to look up the words you don’t know. Save this form and bring it with you to your next checkup.

Name: _______________________________________

Date of birth: ____________

How is your health?   Excellent   Good   Fair   Poor

Have you been to the doctor for checkup within the last year?   Yes   No

Have you been to the dentist for a cleaning within the last year?   Yes   No

Check the symptoms you have now or had in the past.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Now</th>
<th>Past</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cough</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Itching</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Now</th>
<th>Past</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rash</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sore throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach ache</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Speaking

Practice this dialogue with a partner.

Dialogue

**Doctor:** Hello, my name is Dr. Weston. How may I help you?
**Patient:** I have pain in my back.
**Doctor:** Do you have any other symptoms?
**Patient:** Yes, it hurts when I walk.
**Doctor:** I can give you some medicine to help. Take it two times a day.
**Patient:** How long should I take the medicine?
**Doctor:** Take all the medicine. It should last about one week.
**Patient:** Thank you, doctor.

Dialogue

**Doctor:** Hello, my name is Dr. _____________ . How may I help you?
**Patient:** I have pain in my ________________.
**Doctor:** Do you have any other symptoms?
**Patient:** Yes, it hurts when I ________________.
**Doctor:** I can give you some medicine to help. Take it ____________.
**Patient:** How long should I take the medicine?
**Doctor:** Take all the medicine. It should last about ____________.
**Patient:** Thank you, doctor.
What Questions Should I Ask the Doctor?

You have a right and responsibility to ask your doctor questions. This means you can and you should ask questions.

Ask these 3 questions each time you see the doctor:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

It is your doctor’s job to explain clearly the answers to these questions. It is your job to be sure you understand the answers before you leave the doctor’s office.

What Do I Say If I Don’t Understand?

1. Excuse me. Please repeat.
2. Please say that again.
3. Please tell me one more time.
4. What does that mean?
5. Explain it more, please.
6. Please show me a picture.
7. Please show me that word in my dictionary.
8. Please write down what you are saying.
Calling 911

If you or someone else is in immediate danger due to a health emergency, call 911. Practice this dialogue with one other student. Practice this dialogue twice and change who you are. Some students will read their dialogue to the class.

**Caller:** Hello. I need an ambulance.

**911 Operator:** What is the problem?

**Caller:** My father has fallen down the stairs. He can’t move his left arm and is in a lot of pain.

**911 Operator:** What is your address?

**Caller:** My address is 28 Oak Street in Shady Brook, New Jersey.

**911 Operator:** Can you tell me your phone number?

**Caller:** My phone number is 908-763-6890.

**911 Operator:** Tell me your name and your father’s name?

**Caller:** My name is _______________________ and my father’s name is ________________.

**911 Operator:** Please spell your last names.

**Caller:** Our last names are the same. It is spelled ______________.

**911 Operator:** Please don’t move your father. Where is your father now?

**Caller:** He is sitting at the bottom of the stairs.

**911 Operator:** Good. The medics will determine if anything else is broken and will assist him in moving after they ask him a few questions.

**Caller:** O.K. I understand.

**911 Operator:** The ambulance will be there in five or ten minutes.

**Caller:** Thank you so much.
<table>
<thead>
<tr>
<th>Name</th>
<th>How do you feel?</th>
<th>What’s the matter?</th>
<th>How long have you had these symptoms?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maria</td>
<td>Not so good.</td>
<td>I have a headache and dizziness.</td>
<td>2 days</td>
</tr>
<tr>
<td>George</td>
<td>Sick</td>
<td>I have pain in my back.</td>
<td>A week</td>
</tr>
<tr>
<td>Paul</td>
<td>Not well</td>
<td>I am tired all the time.</td>
<td>For a few months</td>
</tr>
<tr>
<td>Sofia</td>
<td>So-so</td>
<td>I can’t stop coughing.</td>
<td>Four days</td>
</tr>
<tr>
<td>Anita</td>
<td>OK</td>
<td>I have gained too much weight.</td>
<td>For about a year</td>
</tr>
</tbody>
</table>

**Who is tired?**

**How long has Sofia been coughing?**

**Who has been sick for the shortest time?**

**What’s the matter with George?**

**How does Anita feel?**

**When did Anita start to gain weight?**

**Who has a headache?**

**How long has Paul had symptoms?**
<table>
<thead>
<tr>
<th>Name</th>
<th>What time is the appointment?</th>
<th>What time did you arrive?</th>
<th>What/who did you bring with you?</th>
<th>What did you say to the doctor when you didn’t understand?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Juan</td>
<td>4:00</td>
<td>3:45</td>
<td>Insurance card</td>
<td>I didn’t say anything.</td>
</tr>
<tr>
<td>Sarah</td>
<td>9 am</td>
<td>9:30</td>
<td>All the medicines that I take</td>
<td>What does that mean?</td>
</tr>
<tr>
<td>Jose</td>
<td>5 pm</td>
<td>5 pm</td>
<td>A friend to help me remember information</td>
<td>Please show me a picture.</td>
</tr>
<tr>
<td>Lee</td>
<td>noon</td>
<td>12:15</td>
<td>a list of questions to ask the doctor and a credit card to pay for appointment</td>
<td>Please say that again.</td>
</tr>
<tr>
<td>Rita</td>
<td>2:30</td>
<td>2:15</td>
<td>a bi-lingual dictionary</td>
<td>Please show me that word in my dictionary.</td>
</tr>
</tbody>
</table>
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,
   
<table>
<thead>
<tr>
<th>Date</th>
<th>Reason</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

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.
   
<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Reaction</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
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 Information Sheet

YOU MUST FILL OUT EVERY LINE ON THIS SHEET!!
Please print all information and use legal name printed on your insurance card.

Who is responsible for patient: Self  Parent  Other ____________________________ How did you hear about us? ____________________________

Legal Name: ____________________________ (Last) ____________________________ (First) ____________________________ (Middle) ____________________________

 Mothers Name if Minor patient: ____________________________  Fathers Name if Minor Patient: ____________________________

Address: ________________________________________________________________

Street: ____________________________ Apt#: __________  City: __________ State: __________ Zip: __________

Date of Birth: ________ / _______ / _______  Sex: □ M  □ F  Marital Status: □ Single  □ Married  □ Divorced  □ Widowed  Other: __________

Home Phone #: __________  Cell Phone#: __________  E-mail Address: __________

Preferred Language: ____________________________  Do you have a Living Will or Medical Advance Directive (circle) Yes-No __________

Ethnicity (circle): Hispanic-  Non-Hispanic-  Unknown  Race (circle): Black-  White-  Asian-  Hispanic-  Other: __________

Employment Status: □ Full-Time  □ Part-Time  □ Retired  □ Unemployed  Other: __________  □ Student  □ Full-Time  □ Part-Time

Employer Name: ____________________________________________________________ Occupation: ____________________________

Employer Address: ____________________________________________________________ Employer Phone: __________

Spouse/Parent Name: _________________________________________________________ DOB: _____ / _____ / _____ Phone#: __________

Last: ____________________________ First: ____________________________

Emergency Contact Name: ____________________________________________________ Phone #: __________  Their Relationship to You: ____________________________

RESPONSIBLE PARTY INFORMATION (if other than parent/spouse)

Head of Household or Parent with Custody of Minor: ____________________________ Relationship to Parent: ____________________________

Mailing address: ____________________________________________________________ tel #: ____________________________

The Doctor's Office: Handout 17
<table>
<thead>
<tr>
<th>POLICY HOLDER (If not patient)</th>
<th>INSURANCE INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name ________________________</td>
<td>First __________________</td>
</tr>
<tr>
<td>Last ________________________</td>
<td>Middle __________________</td>
</tr>
<tr>
<td>Date of Birth ___ / ___ / ___</td>
<td>Relationship to patient __________________</td>
</tr>
<tr>
<td>PRIMARY INSURANCE</td>
<td>EFFECTIVE DATE:</td>
</tr>
<tr>
<td>Insurance Carrier</td>
<td>Name ___________________</td>
</tr>
<tr>
<td>Policy No. ___________________</td>
<td>Group No. ___________________</td>
</tr>
<tr>
<td>SECONDARY INSURANCE</td>
<td>EFFECTIVE DATE:</td>
</tr>
<tr>
<td>Insurance Carrier</td>
<td>Name ___________________</td>
</tr>
<tr>
<td>Policy No. ___________________</td>
<td>Group No. ___________________</td>
</tr>
</tbody>
</table>

**Authorization for Treatment**

I authorize ___________________________ to perform procedures and treatment including administration of medicine and local anesthetics along with other surgical and medical procedures that may be medically necessary. I authorize the release of any medical information necessary (including the release of HIV/AIDS, Mental Health, Substance Abuse- to include alcohol and drugs and any reportable communicable diseases), to process a claim and hereby assign benefits payable to Physician Associates, LLC in the event of another health insurance becoming primary over my health insurance. To further provide continuity of care, I authorize the release of medical information to specialty physicians under contract with Physician Associates, LLC. Furthermore, any services not covered by my insurance will become my responsibility for full payment of services rendered by Physician Associates, LLC.

Patient/Legal Guardian Signature ___________________________ Date ____________