MODULE 1 Communication and Terminology for the Workplace

TOPIC 2 Gathering Patient Information

LEARNING OUTCOMES:

By the end of this lesson, participants will be able to:

- gather patient information using a medical history chart
- be aware of and use opening and closing statements during a consultation

TOPIC	SKILLS	CLB COMPETENCE AREA	COMPETENCIES	PRE-TASKS	TASK	POST TASK
♦ Gathering Patient Information	♦ Listening/ Speaking ♦ Writing ♦ Reading	♦ exchanging information ♦ social interaction ♦ formatted text and unformatted text	♦ apply strategies for understanding medical terminology ♦ use opening and closing statements to conduct patient interviews ♦ analyze a patient case study for specific information ♦ understand format and requirements of a medical history chart	♦ categorize information for gathering patient information ♦ list opening and closing statements for a patient interview ♦ read case studies for specific information ♦ understand terminology in a case study ♦ re-phrase direct questions indirectly ♦ fill in a medical history chart	♦ role-play an interview between a patient and health care professional	♦ listen to role-plays for opening and closing statements

Facilitator's Notes for Module 1
Topic 2: Gathering Patient Information

FACILITATOR PREPARATION

Content

Facilitator should be familiar with the contents of a patient case study, as well as with the format and contents of a medical history chart.

Delivery

As many copies as required of the following handouts should be made:

- Handout 1 — Opening and Closing Sentences
- Handout 2 — Case Study: Mr. Jones
- Handout 3 — Vocabulary and Comprehension Questions
- Handout 4 — Medical History Chart (two copies per participant)
- Handout 5 — Case Study: Mr. Asami
- Handout 6 — Vocabulary and Comprehension Questions
- Handout 7 — Case Study: Ms. Gomes
- Handout 8 — Vocabulary and Comprehension Questions
- Handout 9 — Listening Activity
- Handout 10 — Medical Terminology Abbreviations List (three pages)

Materials needed: Overhead transparencies of completed medical history charts for Mr. Jones, Mr. Asami and Ms. Gomes (Facilitator's Notes) could be used to take up the pre-tasks and tasks. Access to a blackboard and an overhead projector is required.

Methodology

Introduction

(10 minutes)

Elicit from participants the information they would need to obtain when first seeing a patient. Write all the answers on the board. Elicit words such as:

- name
- address
- date of birth
- phone number
- occupation
- Health Card number
- present illness
- past medical history
- childhood illnesses
- previous surgery or hospitalization
- past injuries or traumas
- medications
- allergies
- social history – smoking/alcohol/drugs

Facilitator should emphasize that it is important to follow hospital procedures and policy when gathering patient information.

Handout 10 (three pages) is a reference list of common abbreviations used by health care providers when keeping notes and also sometimes in spoken interactions. These handouts should be distributed to the participants now and referred to throughout the workshop as particular terminology comes up. For example, an electrocardiogram is very often referred to as an ECG or EKG, and pediatrics is known as peds. As terms are discussed, refer to the abbreviations as part of class discussions.

Pre-Tasks

(10 minutes) 1. Facilitator explains that a dialogue involves an opening, a main event and a closing:

OPENING MAIN EVENT CLOSING

Explain that the information on the board is needed for the Main Event: the gathering of patient information. We need some opening sentences to put patients at ease and to establish rapport. We also need some closing remarks to complete the interview.

(15 minutes) 2. Divide the participants into small groups and give each participant Handout 1, with the headings Opening Sentences and Closing Sentences. Ask the participants to brainstorm some appropriate sentences for each heading. When the groups have finished their discussions, write their suggestions on the board. Discuss the suggestions with the class and ask them to decide whether they are appropriate or not. Make sure that the topics in Facilitator's Notes are covered.

(30 minutes) 3. Give the participants the case study on Mr. Jones (Handout 2) and ask them to read it. Distribute Handout 3 and have them answer the vocabulary and comprehension questions with a partner. If necessary, remind them that they are applying previously learned strategies for understanding medical terminology.

(25 minutes) 4. Distribute a medical history chart (Handout 4) to the participants and ask them to transfer the information about Mr. Jones to the chart. Take up the answers with the whole class using a transparency of the completed medical history chart for Mr. Jones (Facilitator's Notes) on an overhead projector.

(20 minutes) 5. Ask participants to think of questions that a health care professional would ask in order to obtain information for a medical history chart. For example, it may be necessary to know if the patient has had any previous operations.

Example of Questions:

Have you had surgery before?
When did you have it?
What kind of surgery did you have?
Where did you have it?

Discuss with participants direct and indirect ways of asking for information. The above questions are an example of direct questions. What kind of information may have to be asked for in an indirect manner?

Example: *(direct)* Do you drink alcohol?

(indirect) Many people have a glass of wine with their dinner. Is that what you and your family do?

(25 minutes) 6. Divide the class into two groups. Give one group the case study for Mr. Asami (Handout 5, 6) and give the other group the case study for Mrs. Gomes (Handout 7, 8). Ask the participants to read the case studies and to answer the questions.

Task

(45 minutes) Explain that participants will have an opportunity to role-play an interview between a health care professional and a patient. Distribute a medical history chart (Handout 4) to each participant.

1. Participants work in pairs. A participant who has worked on the case study for Mr. Asami will be Partner A and Partner B will be a participant who worked on the case study for Mrs. Gomes.
2. Partner A will play the role of Mr. Asami and will answer the questions asked by Partner B. Partner B will play the role of the health care professional. The health care professional asks questions to obtain information to complete the medical history chart (Handout 4). Participants then reverse roles. Partner B assumes the role of Mrs. Gomes and Partner A is now the health care professional. The participants may find it helpful to write the dialogues they create.
3. Remind students to include in their dialogues opening and closing remarks.

Post-Task

(20 minutes) Call upon a pair of participants to present their dialogue between a patient and a health care professional. Ask the rest of the class to listen and to complete the listening chart (Handout 9). Discuss the dialogue afterwards with the whole class.

Handout 1

Opening Sentences

Closing Sentences

FACILITATOR'S NOTES FOR HANDOUT 1

Opening Sentences

- personal introductions
- check identity
- ask what has brought the patient to see the health professional today
- ensure confidentiality
- explain to the patient what you will be doing and how long it may take
- exchange pleasantries where appropriate

Closing Sentences

- seek clarification during and after the process
- encourage questions
- exchange pleasantries when appropriate
- thank the patient for his/her time

Handout 2

Case Study: Mr. Jones

Mr. Jones is a 67-year-old retired mechanic who came to the doctor's office with shortness of breath. He has a long history of coronary artery disease. Twelve years ago he was hospitalized for four weeks with the diagnosis of myocardial infarction. Since that time he has had anginal attacks on moderate exertion which have kept him from working. The anginal pain responded well to sublingual nitroglycerin, and everything seemed to be normal until a month ago. At this time the patient stated that his ankles were swollen and even when he elevated them on pillows the swelling didn't go down. He also said that in order to sleep comfortably he had to prop himself up with two large pillows. Last night he woke up coughing and was very short of breath. He spent the rest of the night sitting in a chair.

This morning Mr. Jones had some mild chest pain but no acute or severe pain. At this visit his breathing was very rapid and he felt that he could not get enough air. He was taking some pills for his high blood pressure and some water pills. He takes his medication regularly. He brought his medications with him, Atenolol for his high blood pressure and Hydrochlorothiazide for water retention. He was a one package a day smoker until he had his heart attack twelve years ago. He is a moderate drinker at four or five beers a week.

A physical examination by the doctor revealed a moderately obese elderly man in obvious acute distress. He was using his accessory muscles of respiration, and was unable to say more than a few words at a time without having to stop to catch his breath. His lips and nails were cyanotic. His blood pressure was 190/110 mmHg in a sitting position. His pulse was 118 beats/min. and the respiratory rate was 32/min. He had a 3+ pitting edema of both ankles and the pretibial areas almost as far as the knees. His liver was enlarged. An electrocardiogram was ordered.

Handout 3

Mr. Jones: Vocabulary and Comprehension Questions

Read the medical terms and, where applicable, draw a line or lines to separate the prefixes, combining forms, and suffixes. Then match the word with the correct meaning.

A. coronary artery disease
B. myocardial infarction
C. anginal pain
D. bilateral ankle edema
E. acute pain
F. cyanotic
G. pitting edema
H. pretibial areas
I. sublingual nitroglycerin
J. electrocardiogram

- swelling
- graphic representation of the heart action
- nitroglycerin taken under the tongue
- severe and sudden pain
- pertaining to the area of the leg in front of the tibia
- chest pain
- swelling on both sides of the ankle
- a condition that reduces the flow of blood to the heart
- blue skin discoloration
- a heart attack

Answer the following questions.

1. What brought him to the doctor's office today? Describe the symptoms.
2. Is he taking any medication?
3. Has he ever been hospitalized before?
4. Has he been sick before?
5. Does he have an ongoing medical problem?
6. What does Mr. Jones do to relieve the chest pain?
7. Does he have a family history of any major illness?

FACILITATOR'S NOTES FOR HANDOUT 2, 3

A. coronary artery disease - a condition that reduces the flow of blood to the heart

B. myocardial infarction - a heart attack

C. anginal pain - chest pain

D. bilateral ankle edema - swelling on both sides of the ankle

E. acute pain - severe and sudden pain

F. cyanotic - blue skin discoloration

G. pitting edema - swelling

H. pretibial areas - pertaining to the area of the leg in front of the tibia

I. sublingual nitroglycerin - nitroglycerin taken under the tongue

J. electrocardiogram - graphic representation of the heart action

Answers:

1. Shortness of breath, swollen ankles and the area above the ankles, mild chest pain, lips and nails blue, enlarged liver.
2. Yes, he takes Atenolol for high blood pressure, Hydrochlorothiazide for water retention and Nitroglycerin for chest pain.
3. Yes, he was hospitalized for a heart attack 12 years ago.
4. Yes, angina attacks.
5. Yes, he has coronary artery disease.
6. He has to sleep sitting up in a chair.
7. Not known.

Handout 4

Name: ______________________________

Date: ______________________________

Date of Birth: D __________ M __________ Y _________

Address: ______________________________

City: ____________________ Postal Code: ______ ______

OHIP: ______________________________

Phone: (H) __________________ (B) __________________

THIS SIDE MAY BE COMPLETED BY PATIENT

HAVE YOU HAD OR DO YOU HAVE?

	YES	NO
High Blood Pressure	( )	( )
Diabetes	( )	( )
Asthma	( )	( )
Epilepsy	( )	( )
Bleeding Problem	( )	( )
Heart Disease	( )	( )
Blood Transfusion	( )	( )
Hepatitis	( )	( )
Problem with Anaesthetic in Self or Family	( )	( )
Chest Pain	( )	( )
Shortness of Breath	( )	( )
Recent Cough/Cold	( )	( )

HAVE YOU RECENTLY TAKEN THESE MEDICATIONS:

	YES	NO
Aspirin	( )	( )
Blood thinners	( )	( )
Water pills	( )	( )
Blood pressure pills	( )	( )
Diabetes medication	( )	( )
Tranquilizers	( )	( )
Steroids/cortisone	( )	( )
Heart pills	( )	( )

DO YOU CURRENTLY HAVE A FAMILY PHYSICIAN WHOM YOU SEE REGULARLY? YES ( ) NO ( )

His/Her Name & Address:

PLEASE LIST MAJOR ILLNESSESS IN CLOSE FAMILY MEMBERS
e.g. DIABETES, HEART DISEASE, HIGH BLOOD PRESSURE, CANCER

____

____

WHAT MEDICATIONS ARE YOU NOW TAKING? ( ) NONE

____

____

____

____

WHAT DRUGS ARE YOU ALLERGIC TO? ( ) NONE

____

HOW MANY CIGARETTES PER DAY? ……………………………………………

HOW MANY OUNCES OF ALCOHOL PER WEEK? ……………………………………

WHAT IS YOUR HEIGHT? …………………….. WEIGHT? ……………………………

PHYSICIAN'S SECTION:

HISTORY OF PRESENT ILLNESS:

____

____

____

____

____

____

____

____

____

PERSONAL/SOCIAL HISTORY: ……………………………………

……………………………………

Bp ………………………………… P ……………… T^0 …………

	Norm	Abn		Norm	Abn
General	( )	( )	Abdomen	( )	( )
ENT	( )	( )	Genital/Rectal	( )	( )
Neck	( )	( )	Extremities	( )	( )
Breasts	( )	( )	Musculo-Skeletal	( )	( )
Lungs	( )	( )	Neurological	( )	( )
Heart	( )	( )	Skin	( )	( )

DESCRIBE ABNORMALITIES:

____

____

IMPRESSION:

____

____

PLAN:

(✓) if ordered

LAB: ( )

EKG: ( )

CXR: ( )

OTHER: ……………………………………

……………………………………… Sgd. ……………………… M.D.

FACILITATOR'S NOTES FOR HANDOUT 4

Name: Mr. Jones

Date:

Date of Birth: D ______ M ______ Y 1931

Address:

City: ______ Postal Code: ______

OHIP:

Phone: (H) ______ (B) ______

THIS SIDE MAY BE COMPLETED BY PATIENT

HAVE YOU HAD OR DO YOU HAVE?

	YES	NO
High Blood Pressure	(✓)	( )
Diabetes	( )	( )
Asthma	( )	( )
Epilepsy	( )	( )
Bleeding Problem	( )	( )
Heart Disease	(✓)	( )
Blood Transfusion	( )	( )
Hepatitis	( )	( )
Problem with Anaesthetic in Self or Family	( )	( )
Chest Pain	(✓)	( )
Shortness of Breath	( )	( )
Recent Cough/Cold	( )	( )

HAVE YOU RECENTLY TAKEN THESE MEDICATIONS:

	YES	NO
Aspirin	( )	( )
Blood thinners	( )	( )
Water pills	(✓)	( )
Blood pressure pills	(✓)	( )
Diabetes medication	( )	( )
Tranquilizers	( )	( )
Steroids/cortisone	( )	( )
Heart pills	(✓)	( )

DO YOU CURRENTLY HAVE A FAMILY PHYSICIAN WHOM YOU SEE REGULARLY? YES ( ) NO ( )

Heart attack 12 years ago 1986

PLEASE LIST MAJOR ILLNESSESS IN CLOSE FAMILY MEMBERS
e.g. DIABETES, HEART DISEASE, HIGH BLOOD PRESSURE, CANCER

WHAT MEDICATIONS ARE YOU NOW TAKING? ( ) NONE

Atenolol
Hydrochlorothiazide
Nitro...

WHAT DRUGS ARE YOU ALLERGIC TO? ( ) NONE

HOW MANY CIGARETTES PER DAY? 1 pkg a day stopped 12 years ago

HOW MANY OUNCES OF ALCOHOL PER WEEK? 4-5 beers/wk

WHAT IS YOUR HEIGHT? .... WEIGHT? ....

PHYSICIAN'S SECTION:

HISTORY OF PRESENT ILLNESS:

- myocardial infarction – 1986
- angina on moderate exertion
- angina controlled by nitro

PERSONAL/SOCIAL HISTORY: retired mechanic

Bp 190/110 P 118 T° ....

	Norm	Abn		Norm	Abn
General	( )	( )	Abdomen	( )	( )
ENT	( )	( )	Genital/Rectal	( )	( )
Neck	( )	( )	Extremities	(✓)	(✓)
Breasts	( )	( )	Musculo-Skeletal	( )	( )
Lungs	( )	( )	Neurological	( )	( )
Heart	( )	(✓)	Skin	(✓)	(✓)

DESCRIBE ABNORMALITIES:

lips, nails cyanotic

IMPRESSION:

- acute distress

PLAN:

(✓) if ordered

LAB: ( )

EKG: (✓)

CXR: ( )

OTHER: ....

.... Sgd. .... M.D.

Handout 5

Case Study: Mr. Asami

Mr. Asami is a 43-year-old gas station attendant who came to see the doctor because he had some mild chest pain which lasted for about two hours.

The patient remembers being told as a child that he had a heart murmur, but was never bothered by it. He was asymptomatic until six years ago when he experienced an episode of palpitations which lasted 30 minutes. This happened again on a few occasions, each episode lasting from a few minutes to more than an hour. He did not feel lightheaded and had no chest pain at these times.

There is no family history of rheumatic fever, diabetes mellitus, arterial hypertension or gout. Mr. Asami never experienced orthopnea, paroxymal nocturnal dyspnea or dyspnea on ordinary exertion. He has never been overweight and he stopped smoking cigarettes five years ago. He drinks a small amount of alcohol occasionally. He has no known allergies. He is 5 feet 11 inches tall and weighs 180 lbs.

Mr. Asami appeared physically fit. He seemed anxious at the time of his visit. His blood pressure was 120/80 mmHg and his radial pulse was 100 beats per minute and regular. His respiration was 20 per minute and his temperature 37.2C (oral). His skin was warm and dry and there was no cyanosis or clubbing of the fingers. His lungs were clear.

An ECG and chest x-ray were ordered.

Handout 6

Mr. Asami: Vocabulary and Comprehension Questions

Read the following words and, where applicable, draw a line or lines to separate the prefixes, combining forms and suffixes. Then match the words with the correct meaning.

A. heart murmur	- blue colouring
B. asymptomatic	- high blood pressure
C. palpitations	- an abnormal sound from the heart
D. rheumatic fever	- the heart is pounding or racing
E. diabetes mellitus	- not showing any symptoms
F. arterial hypertension	- only breathe comfortably when sitting up
G. gout	- a fever that causes damage to heart muscles and valves
H. orthopnea	- high blood sugar or sugar in the urine
I. paroxysmal nocturnal dyspnea	- acute attack of arthritis in a single joint
J. cyanosis	- a bout of difficult breathing at night

Answer the following questions.

1. Was he ever hospitalized before?
2. Has he been sick before?
3. What are his vital signs?
4. Did he have any childhood illnesses?
5. Does he have a chronic illness?
6. What brought him to the doctor's office today? Describe the symptoms.
7. What was the duration of the current symptoms?

FACILITATOR'S NOTES FOR HANDOUT 5, 6

A. heart murmur
B. asymptomatic
C. palpitations
D. rheumatic fever
E. diabetes mellitus
F. arterial hypertension
G. gout
H. orthopnea
I. paroxysmal nocturnal dyspnea
J. cyanosis

- an abnormal sound from the heart
- not showing any symptoms
- the heart is pounding or racing
- a fever that causes damage to heart muscles and valves
- high blood sugar or sugar in the urine
- high blood pressure
- acute attack of arthritis in a single joint
- only breathe comfortably when sitting up
- a bout of difficult breathing at night
- blue colouring

1. No, he was never hospitalized before.
2. He has experienced heart palpitations for the last six years
3. His vital signs are:
    - Blood pressure - 120/80
    - Pulse -100
    - Temperature - 37.2C
    - Respiration - 20
4. He had a heart murmur.
5. No, he does not have a chronic illness.
6. Mild chest pain lasting for about 2 hours.
7. Two hours.

FACILITATOR'S NOTES FOR HANDOUT 5,6/OHT2

Name: Mr. Asami
Date:
Date of Birth: D ______ M ______ Y 1954
Address:
City: ______ Postal Code: ______ ______
OHIP:
Phone: (H) ______ (B) ______

THIS SIDE MAY BE COMPLETED BY PATIENT

HAVE YOU HAD OR DO YOU HAVE?

	YES	NO
High Blood Pressure	( )	(✓)
Diabetes	( )	(✓)
Asthma	( )	(✓)
Epilepsy	( )	(✓)
Bleeding Problem	( )	(✓)
Heart Disease	( )	(✓)
Blood Transfusion	( )	(✓)
Hepatitis	( )	(✓)
Problem with Anaesthetic in Self or Family	( )	(✓)
Chest Pain heart murmur	(✓)	( )
Shortness of Breath	( )	(✓)

HAVE YOU RECENTLY TAKEN THESE MEDICATIONS:

	YES	NO
Aspirin	( )	(✓)
Blood thinners	( )	(✓)
Water pills	( )	(✓)
Blood pressure pills	( )	(✓)
Diabetes medication	( )	(✓)
Tranquilizers	( )	(✓)
Steroids/cortisone	( )	(✓)
Heart pills	( )	(✓)

DO YOU CURRENTLY HAVE A FAMILY PHYSICIAN WHOM YOU SEE REGULARLY? YES ( ) NO ( )

PLEASE LIST MAJOR ILLNESSESS IN CLOSE FAMILY MEMBERS
e.g. DIABETES, HEART DISEASE, HIGH BLOOD PRESSURE, CANCER

WHAT MEDICATIONS ARE YOU NOW TAKING? (✓) NONE

WHAT DRUGS ARE YOU ALLERGIC TO? (✓) NONE

HOW MANY CIGARETTES PER DAY? Stopped 5 yrs. ago

HOW MANY OUNCES OF ALCOHOL PER WEEK? small amount

WHAT IS YOUR HEIGHT? 5' 11' WEIGHT? 180 lbs

PHYSICIAN'S SECTION:

HISTORY OF PRESENT ILLNESS:

- mild chest pain lasting 2 hours
- 6 yrs ago heart palpitations – 30 mins.
- palpitations occur on occasion

PERSONAL/SOCIAL HISTORY: gas station attendant

Bp 120/80 P 100 T° 37.2

	Norm	Abn		Norm	Abn
General	(✓)	( )	Abdomen	(✓)	( )
ENT	(✓)	( )	Genital/Rectal	(✓)	( )
Neck	(✓)	( )	Extremities	(✓)	(✓)
Breasts	(✓)	( )	Musculo-Skeletal	(✓)	( )
Lungs	(✓)	( )	Neurological	(✓)	( )
Heart	(✓)	(✓)	Skin	(✓)	(✓)

DESCRIBE ABNORMALITIES:

IMPRESSION:

- anxious

PLAN:
(✓) if ordered
LAB: ( )
EKG: (✓)
CXR: (✓)
OTHER: ......

Sgd. ...... M.D.

Handout 7

Case Study: Mrs. Gomes

Juanita Gomes is a widow aged 76. She is a former teacher and was born in Puerto Rico. She has lived in Toronto since she was a teenager.

Two years ago she fractured her hip. This was treated by reduction and internal fixation surgery.

She has osteoarthritis and non-insulin dependent diabetes mellitus. She is legally blind but can see shapes and light. Owing to neurologic changes her hearing is slightly diminished. Her vital signs are B.P. + 110/76 P.=86 T.=38.5C. She has 2+ ankle edema. She is 5 feet 2 inches tall and weighs 105 lbs.

Her sacral area and the posterior aspects of her elbows are reddened. Mrs. Gomes normally sleeps through the night but has considerable difficulty getting out of bed because of joint stiffness and limited range of right hip motion.

Two days ago she went to answer the phone and fell on her outstretched left arm. Since then she has had severe pain and swelling on the dorsum of the wrist. She has elevated her hand on pillows and applied ice packs. Despite this the pain has increased and last night she could not sleep.

An x-ray of her left wrist showed a displaced Colles fracture which will require closed reduction under general anaesthesia.

Handout 8

Mrs. Gomes: Vocabulary and Comprehension Questions

Read the following words and where applicable draw a line or lines to separate the prefixes, combining forms and suffixes. Then match the words with the correct meaning.

A. open reduction and internal fixation	- high blood sugar or sugar in the urine
B. osteoarthritis	- blood pressure, pulse, temperature and respiration
C. diabetes mellitus	- back area
D. neurologic	- aligning bones by manipulating them from the outside
E. vital signs	- inflammation of the bone and joints
F. edema	- pertaining to the nervous system
G. sacral area	- bottom of the spine
H. posterior aspects	- swelling
I. Colles fracture	- surgery using pins and screws to align broken bones
J. closed reduction	- being put to sleep
K. general anesthesia	- a fracture of a bone in the wrist

Answer the following questions.

1. Has she had previous surgery?
2. Has she ever been sick before?
3. What chronic illnesses does she have?
4. What brought her to the doctor's office today?
5. How long have the current symptoms lasted?
6. What is her diagnosis?

FACILITATOR'S NOTES FOR HANDOUT 7, 8

A.	open reduction and internal fixation	- surgery using pins and screws to align broken bones
B.	osteoarthritis	- inflammation of the bone and joints
C.	diabetes mellitus	- high blood sugar or sugar in the urine
D.	neurologic	- pertaining to the nervous system
E.	vital signs	- blood pressure, pulse, temperature, and respiration
F.	edema	- swelling
G.	sacral area	- bottom of the spine
H.	posterior aspects	- back area
I.	Colles fracture	- a fracture of a bone in the wrist
J.	closed reduction	- aligning bones by manipulating them from the outside
K.	general anesthesia	- being put to sleep

Answers:

1. Yes, she fractured her hip and had surgery two years ago.
2. Unknown.
3. Osteoarthritis and diabetes.
4. Pain in her left wrist.
5. Two days.
6. Fractured wrist.

FACILITATOR'S NOTES FOR HANDOUT 7, 8/OHT 3

Name: *Mrs. Gomes*

Date: ______

Date of Birth: D ______ M ______ Y *1922*

Address: ______

City: ______ Postal Code: ______ ______

OHIP: ______

Phone: (H) ______ (B) ______

THIS SIDE MAY BE COMPLETED BY PATIENT

HAVE YOU HAD OR DO YOU HAVE?

	YES	NO
High Blood Pressure	( )	(✓)
Diabetes	(✓)	( )
Asthma	( )	(✓)
Epilepsy	( )	(✓)
Bleeding Problem	( )	(✓)
Heart Disease	( )	(✓)
Blood Transfusion	( )	(✓)
Hepatitis	( )	(✓)
Problem with Anaesthetic in Self or Family	( )	(✓)
Chest Pain	(✓)	(✓)
Shortness of Breath	( )	( )
Recent Cough/Cold	( )	(✓)

Hip fracture L surgery 1996

HAVE YOU RECENTLY TAKEN THESE MEDICATIONS:

	YES	NO
Aspirin	( )	(✓)
Blood thinners	( )	(✓)
Water pills	( )	(✓)
Blood pressure pills	( )	(✓)
Diabetes medication	( )	(✓)
Tranquilizers	( )	(✓)
Steroids/cortisone	( )	(✓)
Heart pills	( )	(✓)

DO YOU CURRENTLY HAVE A FAMILY PHYSICIAN WHOM YOU SEE REGULARLY? YES ( ) NO ( )

PLEASE LIST MAJOR ILLNESSESS IN CLOSE FAMILY MEMBERS
e.g. DIABETES, HEART DISEASE, HIGH BLOOD PRESSURE, CANCER

Osteoarthritis

WHAT MEDICATIONS ARE YOU NOW TAKING? ( ) NONE

______

WHAT DRUGS ARE YOU ALLERGIC TO? ( ) NONE

______

HOW MANY CIGARETTES PER DAY?

HOW MANY OUNCES OF ALCOHOL PER WEEK?

WHAT IS YOUR HEIGHT? ......*5'2"*...... WEIGHT? ......*105 lbs*......

PHYSICIAN'S SECTION:

HISTORY OF PRESENT ILLNESS:

- L wrist swollen for 2 days
- fell trying to answer the phone
- legally blind

PERSONAL/SOCIAL HISTORY: *76 year old – retired teacher*

Bp ......*110/76*...... P ......*86*...... T° *38.5*

	Norm	Abn		Norm	Abn
General	( )	(✓)	Abdomen	( )	( )
ENT	( )	(✓)	Genital/Rectal	( )	( )
Neck	(✓)	( )	Extremities	( )	( )
Breasts	(✓)	( )	Musculo-Skeletal	( )	(✓)
Lungs	(✓)	( )	Neurological	( )	( )
Heart	(✓)	( )	Skin	( )	( )

DESCRIBE ABNORMALITIES:

- sacral area, elbows red
- joint stiffness
- limited movement R hip

IMPRESSION:

- *displaced Colles fracture*
- *closed reduction under general*

PLAN:

(✓) if ordered

LAB: ( )

EKG: ( )

CXR: ( )

OTHER: ...✓*XR L wrist*

Sgd. .... M.D.

Handout 9

Listening Activity

Write what the health care professional said to:

1. check identity ______________________________
____
____

2. put patient at ease ______________________________
____
____

3. make sure the patient understands what was said. ______________________________
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Handout 10 *(page 1 of 3)*

Medical Terminology Abbreviations

Abbreviation	*Meaning*
aa	Of each, equal parts
ABR	Absolute bed rest
abd.	Abdomen
ac	Before meals
AD	Admitting diagnosis
A&D	Admission and discharge
ad lib	As desired, if patient so desires
ADL	Activities of daily living
Adm.	Admission
Adm. Spec.	Admission urine specimen
A.M. or a.m. or am	Morning
amb.	Ambulation, walking, ambulatory, able to walk
amt.	Amount
AP or A.P.	Appendectomy
aqua	Water or H_2O
@	At
Approx.	Approximately
B&B or b&b	Bowel and bladder training
bid or B.ID. or b.i.d.	Twice a day
b.m. or B.M.	Bowel movement, feces
B.P. or BP	Blood pressure
BR or br or B.R. or b.r.	Bedrest
BRP or B.R.P. or brp	Bathroom privileges
BSC or bsc	Bedside commode
C	Celsius degree (or centrigrade)
c̄	With
Ca	Cancer
Cath.	Catheter
CBC or C.B.C.	Complete blood count
cc or c.c.	Cubic centimeter
CCU or C.C.U.	Cardiac care unit/coronary care unit
CBR or C.B.R. or cbr	Complete bed rest
C/O or c/o	Complaint of
CO2	Carbon dioxide
CS or cs or C.S. or c.s.	Central supply
CSD or csd or C.S.D.	Central service department
CSR or csr and C.S.R.	Central supply room
CVA or C.V.A.	Cerebrovascular accident or stroke
CPR or C.P.R.	Cardiopulmonary resuscitation
dc or d/c	Discontinue
Del. Rm. or d.r. or DR	Delivery room
Disch. or dish or D/C	Discharge
D. & C. or D&C	Dilatation and curettage
drsg.	Dressing
DOA or D.O.A.	Dead on arrival
Dr. or Dr	Doctor
DX	Diagnosis
ECG or EKG	Electrocardiogram
ED or E.D.	Emergency department
EEG or E.E.G.	Electroencephalogram
EENT or E.E.N.T.	Eye, ears, nose, and throat
E. or E	Enema
ER or E.R.	Emergency room
F	Fahrenheit degree
F.or Fe. or F or Fe	Female
FBS or F.B.S.	Fasting blood sugar
FF or F.F.	Forced feeding or forced fluids

(Continued)

Handout 10 *(page 2 of 3)*

Medical Terminology Abbreviations *(Continued)*

Abbreviation	*Meaning*
ft	Foot
Fx	Fracture
Fx urine or FrU	Fractional urine
gal	Gallon
GI or G.I.	Gastrointestinal
gt	One drop
gtt	Two or more drops
Gtt or G.T.T.	Glucose tolerance test
GU or G.U.	Genitourinary
Gyn. or G.Y.N.	Gynecology
H_2O	Water
hr	Hour
HS or hs	Bedtime or hour of sleep
ht	Height
hyper	Above or high
hypo	Below or low
H.W.B. or hwb or HWB	Hot water bottle
ICU or I.C.U.	Intensive care unit
I&O or I. & O.	Intake and output
Irr	Irregular
Isol. or iso	Isolation
IV or I.V.	Intravenous
L	Litre
Lab. or lab	Laboratory
lb.	Pound
Liq or liq	Liquid
LPN or L.P.N.	Licensed practical nurse
LVN or L.V.N.	Licensed vocational nurse
M	Male
Mat	Maternity
MD or M.D.	Medical doctor
Meas	Measure
mec	Meconium
med	Medicine
min	Minute
ml	Millilitre
Mn or mn or M/n	Midnight
N.A. or N/A	Nursing aide or nursing assistant
n/g tube or ng. tube or n.g.t.	Nasogastric tube
noct	At night
NP	Neuropsychiatric; or nursing procedure
NPO or N.P.O.	Nothing by mouth
nsy	Nursery
O_2	Oxygen
OB or O.B.	Obstetrics
Obt or obt.	Obtained
OJ or o.j.	Orange juice
Ord.	Orderly
OOB or O.O.B.	Out of bed
OPD or O.P.D.	Outpatient department
OR or O.R.	Operating room
Orth	Orthopedics
OT or O.T.	Occupational therapy; or oral temperature
oz	Ounce
PAR or P.A.R.	Postanesthesia room
pc	After meals
Ped or Peds	Pediatrics
per	By, through
p.m. or P.M or pm or PM	Afternoon *(Continued)*

Handout 10 (*page 3 of 3*)

Medical Terminology Abbreviations *(Continued)*

Abbreviation	*Meaning*
PMC or P.M.C.	Postmortem care
PN or P.N.	Pneumonia
po	By mouth
post or p	After
postop or post op	Postoperative
post op spec	After surgery urine specimen
PP	Postpartum (after delivery)
PPBS	Postprandial blood sugar
pre	Before
prn or p.r.n.	Whenever necessary, when required
preop or pre op	Before surgery
preop spec	Urine specimen before surgery
prep	Prepare the patient for surgery by shaving the skin
Pt or pt	Patient; pint
PT or P.T.	Physical therapy
q	Every
qd	Every day
qh	Every hour
q2h	Every 2 hours
q3h	Every 3 hours
q4h	Every 4 hours
QHS or qhs	Every night at bedtime/hour of sleep
qid or Q.I.D.	Four times a day
qam or q am or q.a.m.	Every morning
qod or Q.O.D.	Every other day
qs	Quantity sufficient; as much as required
qt	Quart
r or R	Rectal temperature
Rm or rm	Room
RN or R.N.	Registered nurse
rom or R.O.M.	Range of motion
RR or R.Rm.	Recovery room
Rx	Prescription or treatment ordered by a physician
sw/o	Without
S&A	Sugar and acetone
S&A or S&A. test	Sugar and acetone test
S&K or S.&K. test	Sugar and ketone test
SOB	Shortness of breath
sos	Whenever emergency arises; only if necessary
SPD	Special purchasing department
Spec or spec.	Specimen
ss	One-half
SSE or S.S.E.	Soapsuds enema
stat	At once, immediately
Surg	Surgery
tid or T.I.D.	Three times a day
TLC or tlc	Tender loving care
TPR	Temperature, pulse, respiration
U/a or U/A or u/a	Urine analysis
Ung.	Ointment; unguentine
V.D. or vd	Venereal disease
VDRL	Test for venereal disease
V.S. or VS	Vital signs
WBC or W.B.C.	White blood count
w/c	Wheelchair
wc or W.C.	Ward clerk
wt	Weight

Source: Schniedman, R.B., Lambert, S.S., Wander, B.R.. (1989.) Being a Nursing Assistant. New Jersey: A Brady Book – Prentice Hall.