**Filling Out Forms**

Materials: Vocabulary for Filling Out Forms, Practice Health History Questionnaire, Sample Job Application

Objective: Students will have greater ability to fill out forms confidently.

Vocabulary: See Vocabulary page

1. Ask your students what kinds of forms they have filled out in the last year. Ask if they had to fill out as many forms for different things in their home countries. Ask if they like or don’t like filling out forms and why.

2. When you fill out a form it is important to: follow directions (for example if the form asks you to use blue or black ink), print clearly (you want people to be able to read it), be accurate (correct in every detail), complete (fill in everything you are supposed to).

3. Before you give the students the Vocabulary page, ask them if they can define the words.

4. Give the students the Practice Health History Questionnaire and have them fill them out. Tell them they do not have to answer questions they don’t want to in class. I just want to know what they understand and what they need some help understanding. They can work individually or in pairs, however they are most comfortable.

5. After they have completed the forms, ask students to share any questions they have about the form. Ask the other students to answer the questions first. If no one has the answer you can give it to them.

6. Follow the same procedure for the Sample Job Application.

7. Ask if the students recall any questions on forms they didn’t understand that you haven’t covered. Answer as many questions as possible. Note that health forms can be very long and detailed. Encourage students to ask for help if they don’t understand.

Practice Health History Questionnaire page 1 of 2

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Briefly explain the reason for your visit today:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HISTORY OF PAST ILLNESS: Have you had any of the following

Diabetes….……No Yes Hepatitis ….… …No Yes Strokes..…….…No Yes Tuberculosis… …No Yes Cancer…...…….No Yes Depression….… No Yes Heart Disease.…No Yes Eating Disorder…No Yes Pneumonia…..…No Yes Allergies….…..…No Yes

Please list other Serious Illnesses\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any medications?\_\_\_\_\_\_\_ If yes, which ones?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to anything else?\_\_\_\_\_\_\_\_\_\_ If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: List medications that you currently take, dosage and times taken each day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Operations: Write in the type and the year\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Serious injuries or accidents which you have had:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adapted from MiraCosta College Noncredit ESL Program EL Civics Assessment: Health 28.1 (Advanced) 15 6/17/09

https://www.miracosta.edu/instruction/continuingeducation/esl/downloads/JBHealthAdv28.5.0527\_2009.pdf

Practice Health History Questionnaire page 2 of 2

SOCIAL HISTORY (circle the correct answer)

Marital status: S M W D

Do you exercise regularly? Yes No (What type, how long?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you regularly smoke? Yes No (For how long?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? Yes No (How much, how often?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink caffeinated beverages? Yes No (How many per day?)\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours of sleep do you get on average? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear seatbelts in your car regularly? Yes No

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Family History | If Living  Age Health | | If Deceased  Age at  Death Cause of death | | |
| Father |  |  |  |  |
| Mother |  |  |  |  |
| Brothers/Sisters |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| Husband/Wife |  |  |  |  |
| Sons/Daughters |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

***Thank you! Your time filling out this form completely is appreciated.***

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**Eastside Literacy Workplace Skills Handout**

**Sample Job Application page 1 of 2**

**Personal Section:**

Name: Last First MI

Address: Street Apt.# City State Zip

Phone: Home phone Cell phone

Social Security Number

**Position Applying for:**

Position being applied for

Salary desired

**Past Job Experience:**

Job Title Employer

Address: Street City State Zip Telephone Number

Dates of Employment

Reason for leaving

http://www.eastsideliteracy.org/tutorsupport/documents/HO\_Application.pdf

**Eastside Literacy Workplace Skills Handout**

**Sample Job Application page 2 of 2**

**Past Job Experience:**

Job Title Employer

Address: Street City State Zip Telephone Number

Dates of Employment

Reason for leaving

**Formal Education:**

School City State

Dates Attended Degree earned

School City State

Dates Attended Degree earned

**Professional References:**

Name Address City State Zip

Telephone Email Title

Name Address City State Zip

Telephone Email Title

http://www.eastsideliteracy.org/tutorsupport/documents/HO\_Application.pdf

Vocabulary for Filling Out Forms

Surname/family name – last name

Maiden name – your last name before you were married

M.I. – middle initial

D.O.B. – date of birth (in the U.S. we usually write the month, day, and year, for example: 2/27/67)

Current employer/present employer – the company you are working for now

Former employer/previous employer – the company you worked for before your present employer

Mailing address if different from home address – this is usually a Post Office Box number (P.O. Box)

Emergency contact/relationship – the person to be called if you get sick or hurt and tell your relationship (examples: husband, mother, friend )

Occupation/job/profession – name your profession (examples: janitor, hairdresser, secretary, math teacher, physician)

Qualifications – skills, experience, or knowledge you have to do a job

Felony convictions – have you ever been found guilty for a serious crime, name the crime

\* In the United States it is illegal for companies to ask about your age, religion, marital status, if you have children, your nationality, etc. They can ask if you are able to work in this country legally.