COLBY COMMUNITY COLLEGE
PERSONAL HEALTH HISTORY

NAME _____ CCC STUDENT ID NO. _____
LAST FIRST MIDDLE

ADDRESS _____
STREET CITY STATE ZIP CODE

DATE OF BIRTH _____ GENDER _____ MARITAL STATUS _____ STUDENT PHONE _____

PERSON TO NOTIFY IN AN EMERGENCY _____ RELATIONSHIP _____
(Parent, Guardian, or Spouse)

ADDRESS OF ABOVE _____ HOME PHONE _____ CELL PHONE _____

HEALTH INSURANCE _____
NAME OF COMPANY POLICY NUMBER. TELEPHONE NUMBER

FAMILY HEALTH HISTORY

CHECK EACH ITEM	YES	NO	RELATIONSHIP	CHECK EACH ITEM	YES	NO	RELATIONSHIP	CHECK EACH ITEM	YES	NO	RELATIONSHIP
TUBERCULOSIS	o	o		HEART TROUBLE	o	o		EPILEPSY OR CONVULSIONS	o	o	
DIABETES	o	o		CANCER	o	o		NERVOUS OR MENTAL DISORDER	o	o	
HIGH BLOOD PRESSURE/STROKE	o	o		ASTHMA, HAY FEVER, HIVES	o	o		BLEEDING/CLOTTING DISORDER	o	o	

PERSONAL HEALTH HISTORY

HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING:
(IN LINES OF MULTIPLE STATEMENTS: CROSS OUT THE INAPPLICABLE WORDS.)
EXPLAIN ALL ANSWERS BELOW.

CHECK EACH ITEM	YES	NO	CHECK EACH ITEM	YES	NO
CHICKEN POX	o	o	SEIZURES/CONVULSIONS	o	o
RHEUMATIC FEVER	o	o	HIGH BLOOD PRESSURE	o	o
HEART PROBLEMS	o	o	HIV	o	o
SKIN PROBLEMS	o	o	TUBERCULOSIS	o	o
ALLERGIES/HAY FEVER	o	o	MIGRAINE HEADACHE	o	o
ARTHRITIS	o	o	TOBACCO USE	o	o
THYROID PROBLEMS	o	o	EMOTIONAL/MENTAL PROBLEMS	o	o
STOMACH OR BOWEL PROBLEMS	o	o	MUMPS	o	o
BLOOD DISORDER	o	o	MEASLES	o	o
DIABETES	o	o	SURGERY	o	o
ASTHMA	o	o	ALCOHOL/ DRUG ABUSE	o	o
HEPATITIS/JAUNDICE	o	o	KIDNEY/BLADDER	o	o
ORTHOPEDIC PROBLEMS	o	o			

IF YES, OR ANY OTHER DISEASE/PROBLEMS, GIVE DETAILS

CHECK EACH ITEM	YES	NO	IF YES, LIST:
DO YOU TAKE MEDICATION?	o	o	
ARE YOU ALLERGIC TO ANY MEDICATIONS?	o	o	
DO YOU HAVE ANY ALLERGIES?	o	o	

STATEMENT OF AUTHORIZATION

I hereby certify that the above history is complete to the best of my knowledge. Permission is hereby given to administer recommended immunizations and to perform any necessary treatment and diagnostic studies.

Signature of Student

Date

Signature of Parent or Guardian (If under 18 years of age)

Date

IMMUNIZATION RECORDS, MENINGOCOCCAL FORM, TB QUESTIONNAIRE REQUIRED TO BE ATTACHED TO THIS FORM