

# 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	<input type="radio"/>	<input type="radio"/>		HEART TROUBLE	<input type="radio"/>	<input type="radio"/>		EPILEPSY OR CONVULSIONS	<input type="radio"/>	<input type="radio"/>	
DIABETES	<input type="radio"/>	<input type="radio"/>		CANCER	<input type="radio"/>	<input type="radio"/>		NERVOUS OR MENTAL DISORDER	<input type="radio"/>	<input type="radio"/>	
HIGH BLOOD PRESSURE/STROKE	<input type="radio"/>	<input type="radio"/>		ASTHMA, HAY FEVER, HIVES	<input type="radio"/>	<input type="radio"/>		BLEEDING/CLOTTING DISORDER	<input type="radio"/>	<input type="radio"/>	

## 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	<input type="radio"/>	<input type="radio"/>	SEIZURES/CONVULSIONS	<input type="radio"/>	<input type="radio"/>
RHEUMATIC FEVER	<input type="radio"/>	<input type="radio"/>	HIGH BLOOD PRESSURE	<input type="radio"/>	<input type="radio"/>
HEART PROBLEMS	<input type="radio"/>	<input type="radio"/>	HIV	<input type="radio"/>	<input type="radio"/>
SKIN PROBLEMS	<input type="radio"/>	<input type="radio"/>	TUBERCULOSIS	<input type="radio"/>	<input type="radio"/>
ALLERGIES/HAY FEVER	<input type="radio"/>	<input type="radio"/>	MIGRAINE HEADACHE	<input type="radio"/>	<input type="radio"/>
ARTHRITIS	<input type="radio"/>	<input type="radio"/>	TOBACCO USE	<input type="radio"/>	<input type="radio"/>
THYROID PROBLEMS	<input type="radio"/>	<input type="radio"/>	EMOTIONAL/MENTAL PROBLEMS	<input type="radio"/>	<input type="radio"/>
STOMACH OR BOWEL PROBLEMS	<input type="radio"/>	<input type="radio"/>	MUMPS	<input type="radio"/>	<input type="radio"/>
BLOOD DISORDER	<input type="radio"/>	<input type="radio"/>	MEASLES	<input type="radio"/>	<input type="radio"/>
DIABETES	<input type="radio"/>	<input type="radio"/>	SURGERY	<input type="radio"/>	<input type="radio"/>
ASTHMA	<input type="radio"/>	<input type="radio"/>	ALCOHOL/ DRUG ABUSE	<input type="radio"/>	<input type="radio"/>
HEPATITIS/JAUNDICE	<input type="radio"/>	<input type="radio"/>	KIDNEY/BLADDER	<input type="radio"/>	<input type="radio"/>
ORTHOPEDIC PROBLEMS	<input type="radio"/>	<input type="radio"/>			

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CHECK EACH ITEM	YES	NO	IF YES, LIST:
DO YOU TAKE MEDICATION?	<input type="radio"/>	<input type="radio"/>	_____
ARE YOU ALLERGIC TO ANY MEDICATIONS?	<input type="radio"/>	<input type="radio"/>	_____
DO YOU HAVE ANY ALLERGIES?	<input type="radio"/>	<input type="radio"/>	_____

## 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**