



# 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**

## Colby Community College TB Questionnaire

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Student ID Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**About this Form:**

- Tuberculosis, also known as TB, is a bacterial infection that attacks the lungs and sometimes other parts of the body. It is spread when someone infected with the disease coughs or sneezes and the bacteria is inhaled by someone nearby.
- Colby Community College requires **ALL** students to complete a tuberculosis screening questionnaire, per Kansas Statute #65-129e.
- Please submit this form before August 15 for the fall semester or December 15 for the winter/spring semester to avoid being dropped from pre-registered classes.
- Return to: Student Health

**Please complete the following questions by circling Yes or No\*:**

1. Have you ever had a positive TB test?	Yes	No
2. Have you ever had the BCG vaccine which is given to prevent TB? If yes provide document	Yes	No
3. Have you ever had close contact with someone who was sick with TB?	Yes	No
4. Were you born in a country other than those listed below?	Yes	No
5. Have you ever traveled to and/or resided in a country for more than three months which is not listed below? If yes please write the country or countries in the blank:  _____	Yes	No
<b>*If the answer is yes to any of the questions above Colby Community College requires evaluation by a health care provider.</b>		

### List of Exempt/Low Incidence/TB Countries\*\*

(defined by the Department of Health and Environment)

Albania	Czech Republic	Luxembourg	Turks & Caicos Islands
American Samoa	Denmark	Malta	Great Britain & North Ireland
Andorra	Dominica	Nauru	United States Virgin Islands
Antigua & Barbuda	Fuji	Netherlands	United States of America
Australia	Finland	New Zealand	Wallis & Futuna Islands
Austria	France	Norway	
Bahamas	Germany	Saint Kitts & Nevis	
Barbados	Greece	Saint Lucia	
Belgium	Grenada	Samoa	
British Virgin Islands	Hungary	Slovakia	
Canada	Iceland	Slovenia	
Chile	Ireland	Spain	
Costa Rica	Italy	Sweden	
Cyprus	Jamaica	Switzerland	

**\*\*Students from countries other than those listed above are required to have a TB test.**

**You must show proof of Quantiferon R blood result or current chest x-ray.**

I understand further testing may be required before attending class at Colby Community College. If testing is required I will be responsible for the cost. The information provided in this form is correct to the best of my knowledge.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**If you are not sure on how to answer the questions above please contact the student health office 785-460-5502. If you answer any question YES you MUST go to Student Health**