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

PERSONAL HISTORY

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

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

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.

If yes, or any other diseases/Problems, give details

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_____

_____

_____

_____
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