COLUMBUS STATE COMMUNITY COLLEGE
COLLEGE HEALTH OFFICE
ANNUAL HEALTH EVALUATION

Name: _____ Tech/Dept: _____

Birth date: _____ SS#: _____

Phone: (Home) _____ Phone: (Work)_____

IN THE LAST YEAR HAVE YOU EXPERIENCED ANY OF THE FOLLOWING PROBLEMS ON A RECURRENT OR PROLONGED (OVER TWO WEEKS) BASIS?

1. Persistent cough	No ( )	Yes ( )
2. Cough/Bloody sputum	No ( )	Yes ( )
3. Fever/Chills	No ( )	Yes ( )
4. Excessive fatigue	No ( )	Yes ( )
5. Loss of appetite/Unintentional weight loss	No ( )	Yes ( )
6. Persistent nausea/Vomiting	No ( )	Yes ( )
7. Chronic or recurrent diarrhea	No ( )	Yes ( )
8. Jaundice or Hepatitis	No ( )	Yes ( )
9. Recurrent herpes sores	No ( )	Yes ( )
10. Rash	No ( )	Yes ( )
11. Persistent or Recurrent colds or Sore throat	No ( )	Yes ( )
12. Have you ever had Hepatitis or any other blood borne illness?	No ( )	Yes ( )
13. Do you have any chronic infectious disease?	No ( )	Yes ( )

Comments:

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Signature: _____ Date:_____

Reviewer: _____ Date:_____