

**COLUMBUS STATE COMMUNITY COLLEGE
HEALTH RECORDS OFFICE**

ANNUAL HEALTH EVALUATION

Name: _____ Program: _____

Birth Date: _____ Cougar ID: _____

Phone: (Home) _____ Phone: _____

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:

Student Signature: _____ Date: _____

Reviewer: _____ Date: _____