Program: CNA Program

Semester: ____ Year:

Allied Health
HEALTH HISTORY

(To be filled out by the student)

Last Name	First	MI	Student I.D. Number

Home Address (number & street)	City	State	Zip code

Date of Birth	Home Phone	Cell Phone	Student Email

Emergency Contact (EC)

EC Name	EC Relationship	EC Phone number

Personal Health History (To be filled out by Student)

Do you have, or have you ever had:	Yes	No	Sex: ☐ M ☐ F
Tuberculosis	☐	☐	
Diabetes	☐	☐	
Kidney Disease	☐	☐	
Heart Disease or Hypertension (specify)	☐	☐	
Arthritis or Autoimmune Disease (specify)	☐	☐	
Asthma or Hayfever	☐	☐	
Epilepsy or Seizures	☐	☐	
Head Injury	☐	☐	
Stroke	☐	☐	
Back or Neck Injury	☐	☐	
Chicken Pox	☐	☐	
Measles, Mumps, Rubella (specify)	☐	☐	
Do you have any conditions which could result in a classroom emergency (e.g., epilepsy, fainting, diabetes)? If yes, explain.	☐	☐	
Do you have, or have you had, any limitations of your physical activities for any reason in the past 5 years? If yes, explain.	☐	☐	
Are you currently taking any medication(s)? If yes, list medication(s) and explain.	☐	☐	
Do you have any medication allergies or other allergies? If yes, list allergies.	☐	☐	
Have you had any major injuries or surgeries? If yes, explain.	☐	☐	
Have you received medication or treatment for a mental health problem in the past 5 years? If yes, explain.	☐	☐	

*Select Sign above to add your signature

Signature:

Date: _____

Revised: 6/29/2020