NHTI
Concord's Community College

TEL (603) 230-4043

FAX (603) 230-9308

Health History Form

NHTI Health & Counseling Services
31 College Drive
Concord, NH 03301-7412
nhtihealthservices@ccsnh.edu

This information is strictly **CONFIDENTIAL** and will be used as an aid to provide necessary health care while you are a student. Information supplied will become a part of your health record, will not influence your standing at the College, and will not be released to anyone outside of Health & Counseling except by your written authorization.

This entire form must be completed by all Allied Health Students, Residential Housing Applicants, Sports and student receiving services at Health & Counseling Services. **Health information must be documented on this form** with additional documentation attached as needed. This report must be accompanied by a copy of BLS CPR card (for Allied Health Students) and Insurance Card (for Allied Health students & Sports).

Name _____ DOB _____ Age _____
Last First Middle Initial

Program of Study _____ Student ID# _____

Campus Housing ☐ Yes ☐ No Sports ☐ Yes ☐ No If yes, which sport: _____

Sex: ☐ M ☐ F ☐ Other _____ ☐ Decline to answer Veteran: ☐ Yes ☐ No ☐ Decline to answer

Race: ☐ Black ☐ White ☐ Hispanic/Latino ☐ Native American ☐ Asian / Asian Pacific ☐ Multi-racial ☐ Decline to answer

Home Address _____ Home Phone#_____
Street

_____ Student's Cell _____
City/State/Zip

Student email _____

Emergency Contact _____ Relationship to student _____

Contact's Home # _____ Contact's work # _____

☐ I have received, read, and understand the New Hampshire Bill of Rights/complaint procedure. **Source.** eff. Jan. 1, 2014 (PLEASE CHECK BOX)

I hereby grant permission to an authorized representative of NHTI to secure such medical care as may be required including examination, treatment, and immunization. In the event of an emergency, I hereby give my permission to be treated & transported to the closest emergency facility for appropriate medical treatment. I give permission for NHTI personnel to release pertinent medical/insurance information to that emergency facility, and if necessary to notify my emergency contact listed above.

Signature of Student_____ DATE_____

And/or _____ DATE_____
Parent or Guardian if student is under 18 years

Student Name _____ D.O.B._____

Student's Past History: (CIRCLE if any issues have pertained to YOU and explain below)

ADD/ADHD	Dizziness / Fainting / Blackouts	Intestinal Problems	Self Injury
Anemia	Drug or Alcohol Issues	Joint Disease	Sexually Transmitted Diseases
Anxiety	Eating Disorder	Kidney Disease	Sickle Cell disease / Trait
Asperger's Disorder	Emotional Problems	Learning Disability	Skin disorders
Asthma / lung Disorders	Epilepsy / Convulsions	Leukemia	Sleep Issues
Bi-Polar Disorder	Head Injury / Concussion	Migraine Headaches	Staph Infections / MRSA
Bleeding abnormal	Hearing Loss	Mononucleosis	Stomach problems
Cancer / Impaired Immunity	Heart Disease or Murmurs	OCD	Thyroid Disorder
Chicken Pox	Hepatitis	Orthopedic Injuries	Weight Issues
Depression	High Blood Pressure	PTSD	Other
Diabetes	HIV infections / AIDS	Seizures	

Explain Each Circled Area: **N/A** ☐ _____

_____

_____

Current Medications: prescription or over the counter (Include birth control, herbal and supplements.) **N/A** ☐

_____

_____

Special Dietary Needs: **N/A** ☐ _____

Sleep _____hours a night

Overnight Hospitalizations_____

Current weight _____lbs: ideal weight you would like to see _____lbs

Surgeries_____

Exercise _____times a week

Alcohol consumption a week _____

(Street) Drug use _____

Cigarettes _____ a day Tobacco Use _____a day

Drug/Food Allergies: N/A ☐ **Allergen:** _____ Reaction: _____

Do you have an Epi-pen ? **Yes** ☐ **No** ☐ If yes, explain: _____

Latex allergy? Yes ☐ **No** ☐ **Not sure** ☐

Environmental / Seasonal Allergies: Yes ☐ No ☐ _____

Mental Health Services: N/A ☐ In-patient ☐ Out-patient ☐

When? _____

Where? _____

Family History: Please indicate if any blood relatives have had any of the following, please indicate their relation to you

Cancer _____ Heart Disease _____
Diabetes _____ Substance abuse _____
Mental Health Issues _____ Other: _____
Depression/Suicide_____
Any family member die before the age of 55, list cause of death _____

Student Name _____ D.O.B._____

Immunizations: To be completed by a Healthcare Provider ****

Section 1 (Required for ALL Allied Health, Housing & Sports)

MMR dates (2 shots or 3 titers) MMR 1 _____ MMR 2 _____
(prior to 1980) Measles titer _____ (circle) Immune / not immune
Mumps titer _____ (circle) Immune / not immune
Rubella titer _____ (circle) Immune / not immune
MMR Booster (if needed) _____

Tetanus or Tdap dates Td _____ Tdap _____
(Allied health need proof of 1 tdap booster with up to date tetanus)

Section 2 (Required for Allied Health)

Tuberculin Skin Test (TST): Initial two step testing required for all Allied Health students within 1 year of starting program, then one test annually. Two step testing is done 1 – 3 weeks apart. IGRA blood test may replace TST and XRay.

Date given_____ Date Read_____ Result_____ (Record actual mm of induration).

Date given_____ Date Read_____ Result_____ (Record actual mm of induration).

Interferon-gamma release assays (IGRA or T-Spot) Date _____ result: **(circle)** Negative / Positive

Chest X-Ray (With positive TST) Date: _____ (must be within 5 yrs) Interpretation: _____

Indicate any treatment if applicable: _____

Hepatitis B Vaccine Series (3 Hepatitis shots **with** a positive Hepatitis B titer). A Hepatitis B titer is **required**. If the Hepatitis B titer results are negative (not immune) a second series must be given and then re-tested.

Vaccine #1_____ #2_____ #3_____ Antibody Titer: Date_____ (**circle**) Immune / not immune

Vaccine #4_____ #5_____ #6_____ Antibody Titer: Date_____ (**circle**) Immune / not immune

Varicella (2 shots or positive titer only)

Varicella #1 _____ Varicella #2 _____ **OR** Varicella Titer Date_____ **(circle)** Immune / not immune

Flu Shot date (seasonal) _____

Section 3 (Optional but recommended)

Meningococcal: Dates _____, _____ Meningitis B: Dates _____, _____

*** Healthcare Provider Initial _____ ****

To be completed by a Healthcare Provider (initial page 3 and sign below)****

Student Name: _____ Date of Birth_____

Date of Physical Exam _____ (within 12 months of admission)

Height_____

Weight_____

BP _____ Pulse _____

Eyes _____

Glasses/ Contacts _____

Last eye exam _____

Visual Acuity – (L) OS_____ (R) OD _____ OU_____

Ears_____

Hearing: Right_____ Left_____

Females: Menses: Frequency _____

Duration _____

Issues _____

Throat and mouth_____

Thyroid_____

Skin _____

Heart_____

Lungs_____

Abdomen_____

Orthopedic_____

Spine_____

Feet_____

Joints_____

Extremities_____

May the student participate in all normal college activities including intercollegiate sports? ☐ Yes ☐ No
May the student participate in clinical rotations if applicable (Allied Health Students)? ☐ Yes ☐ No ☐ NA
Is the student medically clear to live independently in Campus Housing? ☐ Yes ☐ No

Has the student ever had a heart murmur, Rheumatic fever, or any other condition that would require pre-medication before dental treatment? ☐ Yes ☐ No

If student is under a healthcare provider's continuing care for any reason, including mental health, a summary from the health care provider regarding his/her treatment and medications must be included in this questionnaire.

Healthcare Provider Signature: _____

Please print name: _____

Address: _____ Date_____ Phone_____

Please complete this form & return by August 1 for Fall and January 1 for Spring Semesters

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RESIDENTIAL CARE AND HEALTH FACILITY LICENSING

Patients' Bill of Rights

Section 151:21

151:21 Patients' Bill of Rights. –

The policy describing the rights and responsibilities of each patient admitted to a facility, except those admitted by a home health care provider, shall include, as a minimum, the following:

I. The patient shall be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care and including being informed of the name, licensure status, and staff position of all those with whom the patient has contact, pursuant to RSA 151:3-b.

II. The patient shall be fully informed of a patient's rights and responsibilities and of all procedures governing patient conduct and responsibilities. This information must be provided orally and in writing before or at admission, except for emergency admissions. Receipt of the information must be acknowledged by the patient in writing. When a patient lacks the capacity to make informed judgments the signing must be by the person legally responsible for the patient.

III. The patient shall be fully informed in writing in language that the patient can understand, before or at the time of admission and as necessary during the patient's stay, of the facility's basic per diem rate and of those services included and not included in the basic per diem rate. A statement of services that are not normally covered by medicare or medicaid shall also be included in this disclosure.

IV. The patient shall be fully informed by a health care provider of his or her medical condition, health care needs, and diagnostic test results, including the manner by which such results will be provided and the expected time interval between testing and receiving results, unless medically inadvisable and so documented in the medical record, and shall be given the opportunity to participate in the planning of his or her total care and medical treatment, to refuse treatment, and to be involved in experimental research upon the patient's written consent only. For the purposes of this paragraph "health care provider" means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providing health care services, including, but not limited to, a physician, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, or psychologist, and any officer, employee, or agent of such provider acting in the course and scope of employment or agency related to or supportive of health care services.

V. The patient shall be transferred or discharged after appropriate discharge planning only for medical reasons, for the patient's welfare or that of other patients, if the facility ceases to operate, or for nonpayment for the patient's stay, except as prohibited by Title XVIII or XIX of the Social Security Act. No patient shall be involuntarily discharged from a facility because the patient becomes eligible for medicaid as a source of payment.

VI. The patient shall be encouraged and assisted throughout the patient's stay to exercise the patient's rights as a patient and citizen. The patient may voice grievances and recommend changes in policies and services to facility staff or outside representatives free from restraint, interference, coercion, discrimination, or reprisal.

VII. The patient shall be permitted to manage the patient's personal financial affairs. If the patient authorizes the facility in writing to assist in this management and the facility so consents, the assistance shall be carried out in accordance with the patient's rights under this subdivision and in conformance with state law and rules.

VIII. The patient shall be free from emotional, psychological, sexual and physical abuse and from exploitation, neglect, corporal punishment and involuntary seclusion.

IX. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the

medical records.

X. The patient shall be ensured confidential treatment of all information contained in the patient's personal and clinical record, including that stored in an automatic data bank, and the patient's written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to be the property of the patient. The patient shall be entitled to a copy of such records upon request. The charge for the copying of a patient's medical records shall not exceed $15 for the first 30 pages or $.50 per page, whichever is greater; provided, that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.

XI. The patient shall not be required to perform services for the facility. Where appropriate for therapeutic or diversional purposes and agreed to by the patient, such services may be included in a plan of care and treatment.

XII. The patient shall be free to communicate with, associate with, and meet privately with anyone, including family and resident groups, unless to do so would infringe upon the rights of other patients. The patient may send and receive unopened personal mail. The patient has the right to have regular access to the unmonitored use of a telephone.

XIII. The patient shall be free to participate in activities of any social, religious, and community groups, unless to do so would infringe upon the rights of other patients.

XIV. The patient shall be free to retain and use personal clothing and possessions as space permits, provided it does not infringe on the rights of other patients.

XV. The patient shall be entitled to privacy for visits and, if married, to share a room with his or her spouse if both are patients in the same facility and where both patients consent, unless it is medically contraindicated and so documented by a physician. The patient has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, including choice of room and roommate, except when the health and safety of the individual or other patients would be endangered.

XVI. The patient shall not be denied appropriate care on the basis of race, religion, color, national origin, sex, age, disability, marital status, or source of payment, nor shall any such care be denied on account of the patient's sexual orientation.

XVII. The patient shall be entitled to be treated by the patient's physician of choice, subject to reasonable rules and regulations of the facility regarding the facility's credentialing process.

XVIII. The patient shall be entitled to have the patient's parents, if a minor, or spouse, or next of kin, or a personal representative, if an adult, visit the facility, without restriction, if the patient is considered terminally ill by the physician responsible for the patient's care.

XIX. The patient shall be entitled to receive representatives of approved organizations as provided in RSA 151:28.

XX. The patient shall not be denied admission to the facility based on medicaid as a source of payment when there is an available space in the facility.

XXI. Subject to the terms and conditions of the patient's insurance plan, the patient shall have access to any provider in his or her insurance plan network and referral to a provider or facility within such network shall not be unreasonably withheld pursuant to RSA 420-J:8, XIV.

Source. 1981, 453:1. 1989, 43:1. 1990, 18:1-6; 140:2, XI. 1991, 365:10. 1992, 78:1. 1997, 108:6; 331:3-8. 1998, 199:2; 388:5, 6. 2001, 85:1, eff. Aug. 18, 2001. 2009, 252:1, eff. Sept. 14, 2009. 2013, 265:3, eff. Jan. 1, 2014.