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Patient Last Name First MI DOB: _____

WSU ID# _____ Phone # _____

Medical History:

Last date of eye exam: _____

Last date of dental exam: _____

Any major illness or health impairment: _____

Hospitalization/Serious Injury: _____

Patient's past history: _____

Any mental or behavioral health history? ____Yes____No_____

Any findings in patient's family health history? _____

Allergy _____

Latex/non-medication allergies ____Yes____No If yes, specify: _____

Medications currently being taken: _____

Please attach immunization record and/or serum antibody laboratory results.

Tuberculosis:

PPD Test: Date placed _____ Date read _____ Results _____mm

OR Read by _____ Initials

Quantiferon: Date: _____ Results _____ (attach copy)
