3+<6,&$/ (;$0,1$7,21

Patient ______________________________ DOB: ____________________

Last Name First MI

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)

______________________________ ______________________________