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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)

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