I 693 History Form

Allcare Medical Clinic, 148 Park Ave North, Renton, WA 98057

Patient Name _____ Date of birth: _____

IN WHAT YEAR DID YOU ARRIVE IN THE UNITED STATES: _____

Do you have or have you had any of the following:	**YES**	**NO**	**If yes, explain and state when, where, how and how long you were treated** *(include medications and inpatient treatments)*
Tuberculosis (*TB infection*)			
Latent Tuberculosis (p*ositive TB blood test but no TB on chest x-ray*)			
Syphilis (*a sexually transmitted infection with potential serious consequences if left untreated*)			*(blood test for syphilis may remain positive indefinitely so also state when and where your last blood test was done)*
Leprosy or Hansen's disease (*a bacterial disease affecting mainly skin, eyes, nose and nerves*)			
Mental health disorders such as depression, bipolar disease or schizophrenia			
Any harmful behavior towards yourself or others associated with any mental or physical disorders			
Drug abuse and or drug addiction			

DO YOU HAVE the following symptoms **AT THIS TIME** (circle all that apply):
fever, night sweats, swollen glands, unexplained weight loss, sore throat, cough, shortness of breath, chest pain, abdominal or pelvic pain, joint pain or swelling, headaches, numbness or balance problems, genital or vaginal sores or discharge, burning on urination, rash or sores on your skin, other: _____

DO YOU HAVE a medical contraindication to **LIVE VACCINES** such as rotavirus, chicken pox, measles, mumps and rubella due to the following (check all that apply):
___ I am pregnant. ___ I have other contraindications as follows: _____
___ I am immunosuppressed due to organ transplant, HIV or other autoimmune conditions.
___ I am immunosuppressed due to treatment with immunosuppressive medications such as chemotherapy, radiation, long term steroid use or biologics; or am within 3 months of having just completed such treatment.

Patient or Guardian's signature: _____ **Date:** _____
Physician comments: _____
( ) Patient will provide records of prior treatment. Other: _____