SOUTHWEST INFECTIOUS DISEASE

MEDICATION LIST

Patient Name:_______________________________________ DOB:_______________________

Have you or a family member ever had a positive tuberculosis (TB) skin test? YES or NO

When was your last TB test? ____

Have you traveled outside the US in the past 5 years? YES or NO

If so, where?____

Pets/Animals with which you have contact: ____

Home Medications:

MEDICATION	STRENGTH	FREQUENCY	REASON	DATE STARTED