TB Screening Questionnaire

Last Name                      First Name                          Date                    Date of Birth

When was your last TB Skin test or Blood Assay?  ______  Result  ______

When was your last Chest x-ray?  _____________________________

Have you had the BCG vaccine [   ] Yes  [   ] No  If yes, Country?  ______

Since you last TB screening, have you worked/volunteered in a location where patients with active TB receive care or service? [   ] Yes  [   ] No  [   ] Don't know

Since your last TB screening, have you traveled outside the US? [   ] Yes  [   ] No  if Yes When and Where?  _____________________________

Since your last TB screening, have you lived with or had close contact with someone with TB disease?  [   ] Yes  [   ] No  [   ] Don't know

Do you work, volunteer or live in a facility that provides medical or social services? [   ] Yes  [   ] No  [   ] Don't know

Have you been treated for TB disease before or taken TB prophylaxis medication? [   ] Yes  [   ] No  [   ] Don't know

If yes, what medication?  _______________  How long did you take the medication?  _______________

Are you taking any TB medications currently?  _____________________________

Since your last TB screening, have you had any of the following symptoms for more than 3 weeks at a time?

[   ] persistent cough    [   ] Unexplained weight loss    [   ] Excessive fatigues    [   ] persistent fever    [   ] Coughing up blood
[   ] Night sweats    [   ] Loss of appetite    [   ] None of the above

Do you have history of any of the following?

[   ] Liver disease    [   ] kidney disease    [   ] diabetes    [   ] Hepatitis B exposure    [   ] Steroid use    [   ] Cancer
[   ] Any immune comprising illness    [   ] Excessive fatigue    [   ] None of the above

Additional follow-up required due to findings?  [   ] Yes  [   ] No

If yes, explain  __________________________________________________________

To be completed By Provider (MD, DO, NP, PA)

Printed Name:  _____________________________  Signature:  _____________________________

Address and phone number of the clinic:  ____________________________________________

Phone: (210) 567-9355  Fax: (210) 567-5903