

TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

PATIENT INFORMATION

Name: _____ Birth Date: _____
 Personal Phone Number: _____ Today's Date: _____
 Job Title: _____ Employer: _____
 Allergies (including latex): _____ Medications: _____
 Reason for Test: Annual Pre-Employment Exposure: Initial / Follow Up

Please answer each of the following questions:

	YES	NO	UNKNOWN
Have you ever had a positive TB test? Date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been treated for TB?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken medicine to prevent TB?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been exposed to TB?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you experiencing any of the following symptoms:			
Fever, chills, night sweats, or easy fatigability?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Involuntary weight loss or a loss of appetite?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged cough with production of sputum or blood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain or shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you received a vaccine in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you received a TB Skin Test in the past 6 months? Date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever received the BCG vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you any steroid medication in the past three months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever received an organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any condition that may suppress your immune system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently receiving or have you received chemotherapy or radiation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Place of birth: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you traveled internationally since your last TB test?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<u>Date of Departure</u>	<u>Date of Return</u>	<u>Travel Destination</u>

Note: It is safe for pregnant and breastfeeding women to undergo a TB screening test.

I have honestly answered these questions to the best of my knowledge.

Employee Signature

Date

Do not write below this line

Reviewing Nurse/Provider

Date

TB Questionnaire Review Only

TST	Placement Date	Initials	PPD Dose	Site		Date Read	Induration	Signature (Placement/Reading)
			5TU/0.1mL	Right FA	Left FA			
QFT	Draw Date	Result		+ Hx	Date of last NEGATIVE CXR	Proof in Record?		
						<input type="checkbox"/> Yes	<input type="checkbox"/> No	