

TB SCREENING QUESTIONNAIRE

_____	_____	_____	/ /
Last Name	First Name	Middle Name	Date of Birth
_____		_____	_____
Address		City	State Zip
_____	_____	_____	
Home Phone	Cell or Work Phone	Today's Date	

CIRCLE ANY OF THE BELOW SYMPTOMS YOU HAVE EXPERIENCED **RECENTLY** (within past 6 months):

Cough Coughing up Blood Fever Weight Loss Tiredness Night Sweats

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Why do you need a TB test today?			
Have you ever had a positive TB skin test or TB blood test?	Yes	No	Don't Know
Have you had a severe reaction to a TB skin test?	Yes	No	Don't Know
Have you ever taken medication for Tuberculosis?	Yes	No	Don't Know
What country were you born in?			
What countries have you lived in?			
Have you had the BCG vaccine?	Yes	No	Don't Know
Have you been in contact with someone who has TB disease?	Yes	No	Don't Know
Have you ever used recreational injectable drugs?	Yes	No	Don't Know
Do you have HIV/AIDS?	Yes	No	Don't Know
Do you have any diseases that could affect your immune system such as cancer, leukemia or other?	Yes	No	Don't Know
Do you have diabetes?	Yes	No	Don't Know
Do you have severe kidney disease?	Yes	No	Don't Know
Are you underweight or do you have a disease which affects how you absorb food and nutrients?	Yes	No	Don't Know
Have you had and intestinal bypass or gastrectomy?	Yes	No	Don't Know
Do you take any prescription medications? If yes, list them below:	Yes	No	Don't Know

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PATIENT NAME: _____ **DOB:** _____
 Last First

CONSENT TO TESTING

I was given the opportunity to ask any questions about the TB skin test, which have been answered to my satisfaction. I agree to return in 48-72 hours to have the test read. I understand the risks and benefits of the TB skin test and request the test be given to me. I understand that if I am symptomatic for TB or if the TB skin test is positive, results may be communicated to:

- The physician with whom I will follow up if medical care is needed (list name and phone number):

- My employer (if the test is part of an employment physical)

 Patient Signature Date

PATIENTS: DO NOT COMPLETE BELOW SECTION – FOR OFFICE USE ONLY

	TST #1	TST #2	CHEST X-RAY
Administration			POSITIVE
Name of person giving test			
Date and Time Administered			
Location (circle one)	L R	L R	
Tuberculin manufacturer			
Tuberculin Exp. Date / Lot #			
Administrator signature			
Results (48-72 hours)			NEGATIVE
Date and Time Read:			
Number of mm induration (across forearm)	_____ mm	_____ mm	
Interpretation of reading (circle)	POS** NEG	POS** NEG	N/A
Reader's Signature			

**Interpreting the TST	
≥ 5mm is positive when:	
<ul style="list-style-type: none"> • HIV infected • Recent contact with persons with TB 	<ul style="list-style-type: none"> • People with fibrotic changes on CXR • Patients with organ transplant and others on immunosuppressant drugs (including prolonged course of oral or intravenous corticosteroids or TNF alpha inhibitors)
≥ 10mm is positive when:	
<ul style="list-style-type: none"> • Born in or a former resident of a country with high TB incidence • Recreational injectable drug user • Mycobacterial lab workers • People who live or work in high risk congregate settings (health care workers, long term care, correctional facilities) • Children younger than 4 years • Infants, children and adolescents exposed to adults in high risk categories 	<ul style="list-style-type: none"> • People with: Diabetes, severe kidney disease, silicosis, cancer of head or neck, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight
≥ 15mm is positive if there are no known TB risk factors	