

RISK FACTOR SCREENING

To be completed only if you have a history of a positive Tuberculin Skin Test

NAME: _____ DATE: _____

Please answer yes or no to the following questions:

1. Have you ever had a positive TB test? _____ If yes, what year? _____
2. Have you ever been diagnosed with TB? _____ If yes, what year? _____
3. Have you previously completed preventative therapy (INH) or treatment for tuberculosis? _____ If yes, what year? _____
4. In the past year have you had:
 - A. Close exposure to someone with TB _____
 - B. Chest x-ray consistent with tuberculosis that was untreated _____
 - C. A problem with substance abuse _____
 - D. Diabetes mellitus (Severe or poorly controlled) _____
 - E. HIV infection _____
 - F. Immuno-suppressive therapy i.e., steroids _____
 - G. Any symptoms of pulmonary TB, such as productive, prolonged cough; chest pain; and/or hemoptysis (bloody sputum) _____
 - H. Any of the following conditions that will increase your risk of TB disease (circle all that apply):
Hematologic & reticuloendothelial diseases (e.g. Leukemia, Hodgkin's disease)
Cancer of the head/neck Intestinal bypass/gastrectomy
Silicosis End stage renal disease
Chronic malabsorption syndromes Low body weight
None of the above
 - I. Any systemic symptoms of TB, such as (circle all that you experienced):
Fever/Chills Night Sweats Easy Fatigability Loss of Appetite
Weight Loss **None of the above**

Signature

Date

Explanation to any "Yes statements and other comments:

Please Return to:
Skip Panter
Office of Medical Education
3600 NW Samaritan Drive
Corvallis OR 97330