TB Risk Factor Screening
To be completed only if you have a history of a positive Tuberculin 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? ______

Please check all that apply:

Any of the following in the last year:
- Close exposure to someone with TB
- Chest X-ray consistent with tuberculosis that was untreated
- A problem with substance abuse
- Diabetes mellitus (Severe or poorly controlled)
- HIV infection
- Immuno-suppressive therapy i.e. steroids
- Any symptoms of pulmonary TB, such as productive, prolonged cough; chest pain; and/or hemoptysis (bloody sputum)
- None of the above

Any of the following conditions that will increase your risk of TB disease:
- 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

Any systemic symptoms of TB, such as:
- Fever/chills
- Night sweats
- Easy fatigability
- Loss of appetite/weight loss
- None of the above

Explanation to any ‘yes’ statements and other comments:

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Signature _____________________________ Date _____________________________