

TB SCREENING QUESTIONNAIRE

_____ Last name	_____ First name	_____ Middle name	_____/_____/_____ Date of birth
_____ Address		_____ City	_____ State
_____ Home phone	_____ Cell or work phone	_____/_____/_____ Today's date	

CIRCLE ANY OF THE BELOW SYMPTOMS YOU HAVE TODAY

- Cough**
 Coughing up blood
 Fever
 Weight loss
 Tiredness
 Night sweats

PLEASE ANSWER THESE QUESTIONS

Why do you need a TB test today? <i>night sweats coughing losing weight</i>			
Have you ever had a positive TB skin test or TB blood test?	Yes	<input checked="" type="radio"/> No	Don't Know
Have you had a severe reaction to a TB skin test?	Yes	<input checked="" type="radio"/> No	Don't Know
Have you ever taken medication for tuberculosis?	Yes	<input checked="" type="radio"/> No	Don't Know
What country were you born in?	<i>Peru</i>		
If you were <u>not</u> born in the U.S., when did you come here?	<i>6 months ago</i>		
Have you had the BCG vaccine?	Yes	No	<input checked="" type="radio"/> Don't Know
Have you been in contact with someone who has TB disease?	<input checked="" type="radio"/> Yes	No	Don't Know
Have you ever used injection drugs?	Yes	<input checked="" type="radio"/> No	Don't Know
Do you have HIV/AIDS?	Yes	No	<input checked="" type="radio"/> Don't Know
Do you have any diseases that could affect your immune system such as cancer, leukemia or other?	Yes	<input checked="" type="radio"/> No	Don't Know
Do you have diabetes?	Yes	<input checked="" type="radio"/> No	Don't Know
Do you have severe kidney disease?	Yes	<input checked="" type="radio"/> No	Don't Know
Are you underweight or do you have a disease which affects how you absorb food and nutrients?	<input checked="" type="radio"/> Yes	No	Don't Know
Have you had an intestinal bypass or gastrectomy?	Yes	<input checked="" type="radio"/> No	Don't Know
Do you take any prescription medications? List them below:	Yes	<input checked="" type="radio"/> No	Don't Know

continue on next page →