

Print Name _____

SS# _____

Section A Tuberculosis Screening		(Please attach all lab results)
The following tests have been performed in my office/facility and under my supervision.		
Test	Date	Result
PPD/ Skin Test	Placed ___ / ___ / ___ Read ___ / ___ / ___	Induration _____ mm Negative Positive (CIRCLE ONE)
Interpreter: _____		
	(print name)	(signature)
Office/Facility Name: _____		
Address: _____		
Telephone #: _____		

Complete Section B **only** if there is a history of positive TB exposure, positive skin test or BCG immunization.

Section B Tuberculosis History Assessment	
Positive TB Exposure or Positive TB Skin Test History	
<input type="checkbox"/> Previous Positive TB Skin Test	Date ___ / ___ / ___
<input type="checkbox"/> BCG Immunization	Date ___ / ___ / ___
Have you been treated with TB medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Treatment: <input type="checkbox"/> INH Other _____	
Last Chest X-Ray: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date _____	
Symptom Review	
Check the symptoms listed below that you currently have or experienced in the past year (must check at least one box):	
<input type="checkbox"/> Persistent cough for more than 2 weeks	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Anorexia (loss of appetite)	<input type="checkbox"/> Fever
<input type="checkbox"/> Unexplained weight loss	<input type="checkbox"/> Bloody sputum
<input type="checkbox"/> Production of sputum	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> None of the above	
Please provide most recent Chest X-ray radiology report if completing Section B.	
Name: _____	Date: _____
(Signature)	