

Tuberculosis (TB) Symptom Screen

Name: _____ Sex: M / F Date of Birth: _____

Last skin test: _____
 (Name, address, city, state, zip, and phone number of place where test was given)

Test date: _____ Results _____ mm Positive ___ Negative ___ Chest x-ray Normal _____ Abnormal _____

Were you treated for: **Latent TB Infection (LTBI)** Yes/No If yes, # of months treated: _____
TB Disease Yes/No If yes, # of months treated: _____
 When/Where _____
 Medications used _____

Today's Date _____

Do you currently have or have had any of the following in the past few months?

Cough:	Yes / No	If yes, for how long? _____
	Are you coughing up blood? Yes / No	If you produce mucus, what color _____
Night sweats:	Yes / No	
Fever:	Yes / No	
Weight loss:	Yes / No	If yes, how many pounds? _____
Weakness:	Yes / No	If yes, how long? _____
Chest pain:	Yes / No	If yes, how long? _____
Short of breath:	Yes / No	If yes, how long? _____

Do you know anyone who has these symptoms? Yes / No
 If yes, what are their name, address, and phone number? _____

Action taken (check all that apply)

No sign of active TB at this time	
Chest X-Ray not needed at this time	
Discussed signs and symptoms of TB with client	
Instructed client to seek health care if begin having TB symptoms	
Patient chose to decline LTBI medication at this time	
Patient chose to begin LTBI medication at this time	
Additional measures needed at this time:	
Isolation	
Given surgical mask	
Chest x-ray needed at this time	
Sputum samples collected	
Referred to physician/clinic (specify):	
Other:	

Signature of person conducting the assessment _____

Signature of client _____ Date _____