Tuberculosis (TB) Symptom Screen

revised 10/2016

Name: ____ Sex: M / F Date of Birth: _________________

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

Test date: ______ **Results**___mm Positive/Negative/Indeterminate **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 ____

Have you ever received the BCG vaccine? Yes No; if yes, when? ____

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 is his/her 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 patient ____ Date _______________________