Tuberculosis (TB) Risk Assessment

revised 10/2016

Name: _____ Date of Birth: _____

Please circle YES or NO.

1. Have you been around a person sick with active TB disease? Yes No
   If yes who/when? _____
2. Have you had an organ transplant? Yes No
3. Have you ever injected drugs? Yes No
4. Have you been in jail, prison, nursing home or homeless housing facility? Yes No
5. Have you ever worked in a lab that processed TB samples? Yes No
6. Do you have/have had?
   a. Diabetes Yes No
   b. Kidney failure with dialysis Yes No
   c. Cancer Yes No
   e. Stomach surgery Yes No
   g. Immune problems (HIV, taking steroids longer than 1 month) Yes No
7. Are you starting/taking a treatment for arthritis? Yes No
8. Have you ever been told you have an abnormal chest x-ray? Yes No
9. Do you have any of the following?
   a. A cough and/or hoarseness lasting more than 3 weeks Yes No
   b. Coughing up mucous or blood Yes No
   c. Fever or night sweats for more than one week Yes No
   d. Weight loss without trying Yes No
   e. Tiredness or weakness Yes No
10. Have you ever had a positive TB skin or blood test? Yes No
11. Have you ever received the BCG vaccine? Yes No
12. Have you lived in, traveled to or had a visitor from outside of the United States in the past few years? Yes No
    If yes, where? _____

_____

Patient Signature/Date _____

Signature of Person Assessing the Patient/Date _____

Title of Person Assessing the Patient _____