

Tuberculosis (TB) Risk Assessment

Please complete this form to help us decide if you fall into a high-risk group that requires a TB skin test.

Name: _____

Date of Birth: _____

Please circle **YES** or **NO**.

- | | | |
|--|-----|----|
| 1. Have you been around a person sick with active TB disease? | Yes | No |
| 2. Have you had an organ transplant? | Yes | No |
| 3. Within the last 5 years, have you lived in, traveled to or had a visitor from a country where TB is common? If yes, what country? _____ | Yes | No |
| 4. Have you ever injected drugs? | Yes | No |
| 5. Have you been in jail, prison or a nursing home? | Yes | No |
| 6. Have you ever worked in a lab that processed TB samples? | Yes | No |
| 7. Do you have? | | |
| a. Diabetes | Yes | No |
| b. Chronic kidney failure with dialysis | Yes | No |
| c. Cancer of the blood or lymph system | Yes | No |
| e. Cancer of the head, neck, or lungs | Yes | No |
| f. Stomach surgery | Yes | No |
| g. Immune problems (HIV or taken steroids like cortisone for longer than one month) | Yes | No |
| 8. Are you starting a treatment for arthritis? | Yes | No |
| 9. Have you ever been told you have an abnormal chest x-ray? | Yes | No |
| 10. Have you had? | | |
| a. A cough and/or hoarseness lasting more than 3 weeks | Yes | No |
| b. A cough with a lot of 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 |
| 11. Have you ever had a positive TB skin test? | Yes | No |

If you answered **NO** to all of these questions, you are not in a high-risk group and do not need a TB skin test.

If you answered **YES** to any of these questions, you fall into a high-risk group and should have a TB skin test or other tests for TB.

Signature/Title of Person Assessing the Client

Date