LHC International Tuberculosis (TB) Risk Questionnaire

DIRECTIONS: Circle Y for yes or N for no.

1. Any past or present liver diseases or hepatitis? Y/N
2. Have you had recent contact with a person known or suspected of having active TB disease? Y/N
3. Have you ever had active tuberculosis disease? Y/N
4. Have you ever had a skin or blood test for tuberculosis? If yes, date ______ Results ________ Y/N
5. If yes to either components of question 4, were you treated for tuberculosis disease or tuberculosis infection because of that test or exam? Y/N
If treated, with what? ______ For how long? ______
6. Have you ever received BCG (TB) vaccine? Y/N
If so, how many times? __ Date of last BCG ______
7. Symptoms: Chest pain Y/N Weakness or Fatigue Y/N Shortness of Breath Y/N Coughing up blood Y/N Fever Y/N Chills Y/N Night sweats Y/N Appetite loss/weight loss Y/N Blood in urine Y/N Prolonged cough for more than 3 weeks Y/N

Signature: ___________________________ Date: ___________________________

This box for Nurse use only

Form Reviewed by: ___________________________ Date: ___________________________

Comments: ___________________________

T-Spot Ordered & Date to Be Drawn: Yes No Date ________

TST Skin Test Placed & Date: Yes No Date ________

7/2015