

# TUBERCULOSIS ASSESSMENT

## SECTION A TUBERCULOSIS SCREENING

(PLEASE ATTACH ALL LAB RESULTS)

The following tests have been performed in my office/facility and under my supervision.

Test	Date		Result
PPD/ Skin Test	Placed ___/___/___ Read ___/___/___	Induration _____ mm	Negative Positive (CIRCLE ONE)

Interpreter: \_\_\_\_\_  
(print name) (signature) (license #) (title)

Office/Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Complete Section B **only** if there is a history of positive TB exposure, positive skin test or BCG immunization.

## SECTION B TUBERCULOSIS HISTORY ASSESSMENT

Positive TB Exposure or Positive TB Skin Test History

- Previous Positive TB Skin Test Date \_\_\_/\_\_\_/\_\_\_  
 BCG Immunization Date \_\_\_/\_\_\_/\_\_\_

Have you been treated with TB medication?  Yes  No

Treatment:  INH Other \_\_\_\_\_

Last Chest X-Ray:  Positive  Negative Date \_\_\_\_\_

Symptom Review

Check the symptoms listed below that you currently have or experienced in the past year (must check at least one box):

- |   |  |
|---|--|
| <input type="checkbox"/> Persistent cough for more than 2 weeks | <input type="checkbox"/> Night sweats        |
| <input type="checkbox"/> Anorexia (loss of appetite)            | <input type="checkbox"/> Fever               |
| <input type="checkbox"/> Unexplained weight loss                | <input type="checkbox"/> Bloody sputum       |
| <input type="checkbox"/> Production of sputum                   | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> None of the above                      |  |

Please provide most recent Chest X-ray radiology report if completing Section B.

Name: \_\_\_\_\_  
(Signature)

Date: \_\_\_\_\_