Tuberculosis Screening:

Date Given:_______ Site:________ Lot Number:_________ Given by:______

Date Read:________ Induration________mm Result:(circle one) Pos. or Neg.
(48 – 72 hours after)

Signature and title of
interpreter:____

Section B

*Complete this section *ONLY* if there is a history of positive TB exposure, positive skin test.

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 have experienced in the past year or currently have:

_ Persistent cough for more than 2 weeks _ Night sweats

_ Anorexia (loss of appetite) _ Fever

_ Unexplained weight loss _ Bloody sputum

_ Production of sputum _ Shortness of breath

_ None of the above

*Please provide most recent Chest X-ray results if completing section B

Nurses Signature:______________________________Date:_____________

Office / Clinic Information:

Clinic:____

Address:______________________________State:__________ Zip:_______

Office Phone:____________________________ Office Fax:_____________