

TB Questionnaire

Date: _____

Name: _____

Because you have had a positive skin test reaction to the TB test in the past, we need to determine whether you have any symptoms of active TB. Please answer the following questions.

1. Do you have a productive cough? _____
2. Have you had an unexplained weight loss? _____
3. Do you have night sweats? _____
4. Do you have symptoms of exhaustion? _____
5. Do you have any unexplained fever? _____
6. Have you been exposed to anyone with TB in the past? _____
7. Have you ever lived in another country? ___ If so, where? _____
8. What was the year of your last chest x-ray? _____
9. Have you ever received the BCG vaccine for tuberculosis? _____
10. Have you ever had a positive reaction (a lump 2-3 days after placed) to a TB test in the past? _____
11. If so, what was the size of the induration (lump) in millimeters? _____
12. Did you have a chest x-ray after the positive test? _____
13. If so, what were the results of the x-ray? _____
14. Were you evaluated in a Chest Clinic for the positive TB test? If yes, when _____
15. If so, were medications prescribed for you? _____
16. Did you complete the entire course of the medication? _____

Signature of Student

Date/Time

Signature of Provider

Date/Time