

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: _____