AMERICAN LUNG ASSOCIATION.

TB EDUCATION PROGRAM

TB SKIN TEST PATIENT QUESTIONNAIRE

You can type your information directly into this form. You will not be able to save; print before closing.

Please check answers. If the question is unclear, ask for an explanation.

Yes	No	
○	○	Are you pregnant? If yes, due date_____. Need written/verbal consent from healthcare professional.
○	○	Have you ever had a positive TB Skin Test? If yes, where_____ when_____
○	○	Are you sick today with a severe cold, infection or flu?
○	○	In the past 4-6 weeks, have you had a vaccine for measles, chickenpox, shingles, yellow fever, typhoid or a nasal flu vaccine? If yes, which ones _____ date(s) _____
○	○	Are you now or have you recently received chemotherapy, radiation or immunosuppressive therapy for a major
		disease (i.e., cancer)? If yes, please explain _____
○	○	Have you had a HIV test (test for AIDS)? If yes, when_____
○	○	Personal history of TB infection or disease? If yes, when _____where treated _____
○	○	Family history of TB? If yes, who_____when _____
○	○	If you are foreign born, have you had BCG vaccine? If yes, when? _____
○	○	Have you had a blood test for TB (i.e., QTF Gold)? If yes, when _____result _____ (This test requires a doctor's order for a blood draw.)
○	○	Do you drink alcohol? Amount per day _____
○	○	Do you smoke cigarettes? How many cigarettes per day_____
○	○	Do you take any medications? If yes, please list _____ _____

Check all that apply to you:

○ Diabetes
○ Organ transplant
○ Kidney problems
○ HIV infection or AIDS
○ Silosis
○ Abnormal chest x-ray (old healed TB)
○ Injection drug use
○ Gastrostomy/Jejunoileal bypass
○ Blood disorder (Leukemia/Lymphoma)
○ Recent weight loss of >10% of ideal body weight
○ Liver problems
○ Viral Hepatitis (type_____)
○ Resident or employee of homeless shelter, correctional facility, long-term care or acute care facility, other healthcare facility or group home

Last Name _____ First Name _____ MI__ Parent/Guardian _____
Date of Birth _____Age _____ ○ Male ○ Female Nation of Origin _____
Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated
Race: ○ Caucasian ○ African American ○ Asian ○ Other_____
Ethnicity: ○ Hispanic ○ Non-hispanic ○ Year arrived in U.S._____
Local Address _____
City _____ State _____ Zipcode _____ County _____
Daytime Phone _____ Email _____
Food/Medication/Latex Allergies _____
Family Physician Name _____ Phone _____ Location _____
Why do you need this text, x-ray or exam?

1. ○ Work ○ School ○ Volunteer Where? _____ Other _____
2. ○ Contact to active TB case
3. TB symptoms (circle all that apply) ○ Fever ○ Cough ○ Weight loss ○ Night sweats ○ Fatigue ○ Chest pain
   Other symptoms _____