



## TB SKIN TEST PATIENT QUESTIONNAIRE

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

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant? If yes, due date _____ . Need written/verbal consent from healthcare professional.
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a positive TB Skin Test? If yes, where _____ when _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you sick today with a severe cold, infection or flu?
<input type="checkbox"/>	<input type="checkbox"/>	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) _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you now or have you recently received chemotherapy, radiation or immunosuppressive therapy for a major disease (i.e., cancer)? If yes, please explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you had a HIV test (test for AIDS)? If yes, when _____
<input type="checkbox"/>	<input type="checkbox"/>	Personal history of TB infection or disease? If yes, when _____ where treated _____
<input type="checkbox"/>	<input type="checkbox"/>	Family history of TB? If yes, who _____ when _____
<input type="checkbox"/>	<input type="checkbox"/>	If you are foreign born, have you had BCG vaccine? If yes, when? _____
<input type="checkbox"/>	<input type="checkbox"/>	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.)
<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol? Amount per day _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke cigarettes? How many cigarettes per day _____
<input type="checkbox"/>	<input type="checkbox"/>	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/Jejunioileal 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 \_\_\_\_\_