American Lung Association.

Tuberculosis Education

TB SKIN TEST PATIENT QUESTIONNAIRE

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

Yes	No	
☐	☐	Have you ever had a positive TB Skin Test? If yes, when _____
☐	☐	Have you ever had a positive TB Blood Test? If yes, 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 ? If yes, when _____
☐	☐	Personal history of TB infection or disease? If yes, when _____ where treated _____
☐	☐	Family history of TB? If yes, who _____ when _____
☐	☐	Have you had BCG vaccine? If yes, when? _____
☐	☐	Do you drink alcohol? Amount per day _____
☐	☐	Do you smoke cigarettes/e-cigarettes? How much 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 (please circle): American Indian or Alaska Native Asian Black or African American Native Hawaiian or other Pacific Islander White Other (please specify) _____

Ethnicity: ○Hispanic or Latino ○Non-hispanic

Local Address _____

City _____ State __ Zipcode _____ County _____

Daytime Phone _____ Email _____

Food/Medication/Latex Allergies _____

Family Physician Name _____ Phone _____ Location _____

Why do you need this test, x-ray, or exam?

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