TUBERCULOSIS RISK ASSESSMENT AND QUESTIONNAIRE

Project Code: _____

PLEASE PRINT

Name: Last	First	Middle Initial	Birthdate	Sex	Race

Address: Street	City	County	State	Zip

Home Phone #:	Work Phone #:	Department

Health Insurance Policy/ID#:	Social Security #:	Primary Language	Birth Country

Are you a US citizen?

Yes ☐ No ☐

If No, Country _____

TB TESTING HISTORY

Type	Date	Result
_____	_____	_____
_____	_____	_____

CHEST X-RAY

Date	Result
_____	_____
_____	_____

Reason for Pulmonary History: [ ] New Employee [ ] Annual Screening [ ] Other _____

Yes	No	*Please present to a physician or registered nurse for assessment.*
		Completed preventive treatment. If yes, indicate dates of treatment: From _____ To _____ and number of months on treatment _____
		A cough exists. If yes, is it: Productive [ ] Non-Productive [ ]
		Night sweats
		Hemoptysis (spitting up blood)
		Smoker, if yes, number of years: _____
		Chest pains
		Weight loss How many _____lbs. in _____months
		Fever
		Weakness/tired/general malaise
		Loss of appetite
		Difficulty in breathing
		Recent URI prolonged > 7-10 days

Have you been diagnosed with an immunosuppressive disease and/or you taking any immunosuppressant medication? ❑ Yes ❑ No

If yes, Explain _____

SIGNATURES

The information given is true to the best of my knowledge. The general symptoms of the disease and reasons for screening and surveillance tests have been explained and appropriate referrals offered.

PATIENT: Printed Name	Signature:	DATE:

PHYSICIAN/NURSE: Printed Name	Signature:	DATE:

TUBERCULOSIS RISK ASSESSMENT AND QUESTIONNAIRE

FORM No. 821

PURPOSE

The purpose of this form is to document the current pulmonary history, the results of any previous TB skin tests and/or chest x-rays.

INSTRUCTIONS

Patient Identification Information- Complete demographic information. *(Please print)*

TB Skin Test History- Enter the type, date, and result of any past tests for TB infection.

Chest X-Ray- Enter the date and result of any past chest x-rays.

Reason for Pulmonary History- Check reason for obtaining the patient history. (i.e. new employee, annual screening, or other)

Symptom Assessment- Take the pulmonary history sheet to a physician or Public Health Nurse (PHN). The healthcare provider will complete the Yes/No questions.

Additional History/Risk Factors Referral Information- Record any additional risk factors or history that may dispose the patient to side effects of medications or increase their risk of having active tuberculosis.

Signature/Date- Have patient/employee print name, sign, and date. The nurse/physician should also print name, sign, and date as indicated.

OFFICE MECHANICS AND FILING

This form is to be filed in the patient's record and entered into the ERS as a permanent part of the record as appropriate.

RETENTION PERIOD

This form will be incorporated into the client's medical record and retained according to Agency Policy for that record type.

Note: Located on the Intranet under TB Program. *Revised 11-24-14*