## Tuberculosis (TB) Symptom Screen

Name:		M F Da	te of Birth:	
Last skin test:	(Nama address situ et	ate, zip, and phone number of place	where test was given)	
	(Name, address, city, sta	ate, zip, and phone number of place	where test was given)	
Test Date:	Results mm	Positive Negative	Chest X-Ray: Norn	mal Abnormal
Were you treated for	or: Latent TB infection (LTB	<b>I)</b> ? Yes No #Months _	<b>TB Disease</b> ? Yes _	No #Months
If yes, When?	Where?			
Name of Medicat	ions:			
Today's Date _				
D	-1.0		V	NI-
Do you have a coug		# Days	Yes	
If yes, how long have you had it? What color is the mucus?				# Months
WHAT COIDE IS TH	e mucus!	Are you cougning up bloc	ou: res	No
Do you have night	sweats?		Yes	No
Do you have fevers	?		Yes	No
Have you lost weight without trying?		Yes	No	# Pounds
Have you been tired or weak?			Yes	No
If yes, how long has it lasted?		# Days	# Weeks	# Months
Do you have chest pain?			Yes	No
If yes, how long has it lasted?		# Days	# Weeks	# Months
Do you have shortn	ness of breath?		Vas	No
Do you have shortness of breath?  If yes, how long has it lasted?		# Davs	# Weeks	# Months
Do you know anyone who has these symptoms?				No
Name	Address		Phone	<del></del>
Action Taken (	(check all that apply)			
	No sign of active TB at this time			
	Chest X-ray not needed at this time			
	Discussed signs and symptoms of			
Client knows to seek health care if symptoms of TB appear				
	Further action needed  • Isolated			
	Given surgical mask			
Chest X-Ray is needed				
Sputum samples are needed				
	Referred to Doctor / Cli	nic (Specify):		
l	Other (Specify):			
Signature of Persor	Making the Assessment			
Signature of Client		Γ	)ate	

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