[redacted]sis (TB) Symptom Screen

Name: _____ M ___ F ___ Date of Birth: _____

Last skin test: _____

[redacted]dress, city, [redacted]r of place where test w[redacted]

Test Date: _____ **Results** _____ mm ___ Positive ___ Negative __ **Chest X-Ray**: Normal ___ Abnormal ___

Were you treated for **Latent TB infection (LTBI)**? Yes [redacted] #Months **TB Disease**? Yes [redacted] #Months ___

If yes, **When**? _____

Name of Medications: _____

Today's Date _____

Do you have a cough?			Yes _____	No _____
If yes, how long have you had it?	# Days _____	# Weeks _____	# Months _____	
What color is the mucus? _____	Are you coughing up blood?		Yes _____	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 shortness of breath?			Yes _____	No _____
If yes, how long has it lasted?	# Days _____	# Weeks _____	# Months _____	
Do you know anyone who has these symptoms?			Yes _____	No _____

Name _____ Address _____ Phone_____

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 TB with client	
[redacted]	
• Sputum samples are needed	
• Referred to Doctor / Clinic (Specify):	
• Other (Specify):	

Signature of Person Making the Assessment _____

Signature of Client _____ Date _____