Tuberculosis (TB) Symptom Screen

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

Last skin test: _____
(Name, address, city, state, zip, and phone number of place where test was given)

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

Were you treated for: **Latent TB infection** (**LTBI**)? Yes __ No ___ #Months ___ **TB Disease**? Yes __ No __ #Months ___

If yes, **When**? _____ **Where**? _____

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	
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 / Clinic (Specify):	
• Other (Specify):	

Signature of Person Making the Assessment _____

Signature of Client _____ Date _____