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?  If yes, how long have you had it? | # Days | Yes  # Weeks | No  # 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?  If yes, how long has it lasted? | # Days | Yes # Weeks | No # Months |
| Do you have chest pain?  If yes, how long has it lasted? | # Days | Yes # Weeks | No # Months |
| Do you have shortness of breath? If yes, how long has it lasted? | # Days | Yes # Weeks | No # 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

GA DPH TB Unit Rev. 12/2011