25	01	01	-	00001
COUNTRY	INSTITUTION	FACILITY		TB SCREENING #

CRF 01: SYMPTOMS AND RISK FACTORS

	Tobacco	Yes ☐	No ☑	NA ☐	Current?	Yes ☐	No ☐
	Drug abuse	Yes ☐	No ☑	NA ☐	Current?	Yes ☐	No ☐
5.	Has the client ever been treated for TB?	Yes ☐	No ☑		If Yes,	☐☐☐☐	

TUBERCULOSIS SYMPTOM SCREENING

Do you have the following? (Please insert the appropriate response)

S/N	Symptom(s)	Response(s)		Date started
1.	Cough of any duration	Yes ☐	No ☑	☐☐/☐☐/☐☐☐☐ DD MM YYYY
2.	Coughing up blood stained sputum	Yes ☐	No ☑	☐☐/☐☐/☐☐☐☐ DD MM YYYY
3.	Fever	Yes ☑	No ☐	01/01/2019 DD MM YYYY
4.	Noticeable weight loss or failure to thrive in children	Yes ☑	No ☐	15/01/2019 DD MM YYYY
5.	Excessive sweating at night	Yes ☐	No ☑	☐☐/☐☐/☐☐☐☐ DD MM YYYY
6.	Others	Yes ☐	No ☑	
	Specify			☐☐/☐☐/☐☐☐☐ DD MM YYYY

* Please give the date for each question above. (If the patient does not remember exactly date, ask him/her if it was the beginning of the month; or the mid-month or the end of the month. If it is the beginning of the month write 1ST of that particular month; if mid-month write 15TH of that particular month and if end of the month write 30TH of that particular month.

Which place did you first seek care for the above symptoms

Regional Hospital	Yes ☐	No ☑		
District Hospital	Yes ☑	No ☑		
Mission	Yes ☐	No ☑		
Drug Shop	Yes ☐	No ☑		
Public health centre	Yes ☐	No ☑		
Private Clinic	Yes ☐	No ☑		
Private hospital	Yes ☐	No ☑		
Herbalist	Yes ☐	No ☑		
Other	Yes ☐	No ☑	Specify	.....