

HEALTH QUESTIONNAIRE TUBERCULOSIS (TST/IGRA) <i>This questionnaire is intended for the person who is checked.</i>	Yes	No	Unknown
1. Have you ever suffered from tuberculosis (TB)? If yes, when (year)?.....			
2. Did you ever have a tuberculin skin test (TST) for tuberculosis (TB) performed? If yes, when (year)?..... Result: positive / negative / unknown			
3. Did you ever have a blood test for tuberculosis (TB)? If yes, when (year)?..... Result: positive / negative / unknown			
4. Did you receive a BCG vaccination (vaccine for tuberculosis)? If yes, when?.....			
5. Did you have any other vaccination during the past 6 weeks? If yes, name of the vaccine and when?.....			
6. Do you have any health complaints? If yes, do you have one or more of the following symptoms?			
- Coughing (longer than 3 weeks)			
- Fever (> 38.0 °C / >100.4 Fahrenheit)			
- Night sweats			
- Weight loss			
- Poor growth / abnormal growth curve			
7. Have you ever been treated by a specialist? If yes, what kind of specialist? What for? When?			
8. Have you ever been tested for HIV? If yes, when (year)? What was the result? positive / negative / unknown			
9. Are you currently using any medication? If yes, which medication?.....			

The answers in this questionnaire will be used for medical purposes only and are part of the medical file.

First name
Last name
Date of birth
Gender Male / Female

BSN
Home Address
Phone number
General Practitioner