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 _____