

TB SCREENING QUESTIONNAIRE

CLIENT _____ DOB: _____ ID #: _____

Last First

1. Have you recently coughed up blood?	Yes	No
2. Have you been coughing for more than 2 – 3 weeks?	Yes	No
3. Have you lost more than 5 lbs in the last 2 months?	Yes	No
4. Have you had frequent fevers in the last month?	Yes	No
5. Have you had unusual sweating, especially at night?	Yes	No

- If **“Yes”** to question 1 or **“Yes”** to two-or-more of the other symptoms; go to **Evaluate for Active TB** below
- Other findings (**“Yes”** to one symptom): Refer to medical provider as needed, depending on the severity of the symptom

Have you ever had a TB Test?	Yes	No		
<u>What type?</u>			<u>What was the result?</u>	
TB Skin Test	Yes	No	Positive	Negative
TB Blood Test	Yes	No	Positive	Negative

Do you have proof of your TB test*? Yes No

- Previous TB test documentation: Record date and result:
- Copy TB test document for program and client's records

TB test Date

_____ mm
_____ IU
_____ Spots

*Current, acceptable TB tests are Mantoux TB skin test, QuantiFERON blood test, TSpot blood test

SUMMARY (Check all applicable)

If TB Test is:

Not known/No Previous TB test Done: Refer clients for TB testing ASAP (7 days max)

Negative (no documentation available): Refer client for TB testing ASAP (7 days max)

Negative (documented as done within the last 3 months): No TB test needed now

Positive History (no documentation): Refer for an evaluation of TB testing ASAP (7 days max)

Positive History (documented, date and size recorded above):

Chest x-ray needed within 7 days of admission UNLESS client presents documented proof of a normal x-ray done within the last 3 months. Copy x-ray report for clinic record and record date here: **X-ray Date** _____

____ **Evaluate for Active TB** (coughing up blood or two-or-more other symptoms): Contact TB Control to discuss situation – (619) 692-5565

Staff completing this form: _____ **Date:** _____