Complete this form ONLY if you have ever had a POSITIVE TB Skin Test
Tuberculosis Screening Questionnaire

Below is a list of signs and symptoms for active pulmonary tuberculosis. Please answer each question by circling “Yes” or “No”.

1. When was your last chest x-ray (CXR) taken? ____________________________
2. Were the results of the CXR positive or clear(normal)? ____________________________
3. Have you ever received BCG vaccine? ____________________________

4. Have you ever had a positive TB skin test? Yes No
5. Have you ever had close contact with anyone who was sick with TB? Yes No

6. Have you experienced any of the following symptoms within the past year?
   a. Persistent productive cough? Yes No
   b. Coughing up blood? Yes No
   c. Chest pain? Yes No
   d. Unexplained fever lasting more than 3 days Yes No
   e. Unexplained night sweats? Yes No
   f. Unexplained sudden weight loss? Yes No

Considering the list of countries/continents below:
   a. Africa
   b. Asia: China, Mongolia, Vietnam, Korea, Indonesia, India, Pakistan & Bangladesh
   c. Eastern Europe: Russia and former Soviet Union States, Armenia
   d. Latin America: Mexico, Guatemala, South America
   e. Caribbean Islands: Jamaica, Dominican Republic, Haiti, Cuba, Trinidad & Tobago
   f. Pacific Islands including the Philippines; excluding Hawaii

1. Were you born in one of these countries? Yes No
2. Have you stayed in one of these places for one month or longer? Yes No
3. Have you lived with or been in close contact with someone who stayed or lived in one of these countries for one month or longer? Yes No

If you answered “Yes” to any of the above questions or cannot receive the PPD/ tuberculin skin test provide an explanation below:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

I certify that the information contained on this TB Questionnaire is true and correct. I hereby understand that if any of the above responses are “Yes” that I will be re-evaluated by a healthcare provider to rule out the presence of active tuberculosis.

________________________________________________________________________
________________________________________________________________________

Print Name ____________________________ Date ____________________________
Signature ____________________________

Referral to healthcare provider: Yes No

Approved: 3/2010; Revised 3/2014