CITY OF RACINE HEALTH DEPARTMENT
TB SCREENING QUESTIONNAIRE

_____ mm

Please fill out all blanks and answer all questions below to the best of your knowledge.

_____ _____ _____ _____ / _____ / _____
Last Name First Name Middle Initial Date of Birth (MM / DD / YY)

_____ _____ _____ _____
Address City State Zip

(_____) _____ _____
Phone Number Physician's Name

Circle any symptoms you have today

Cough for More Than Three Weeks | **Coughing Up Blood** | **Fever** | **Unplanned Weight Loss** | **Tiredness** | **Night Sweats**

Please answer these questions

	Yes	No	Don't Know	
1.	☐	☐	☐	Have you had a previous TB skin test or blood test?
2.	☐	☐	☐	Have you had a severe reaction to a TB skin test in the past?
3.	☐	☐	☐	Have you ever been treated with medication for tuberculosis?
4.	☐	☐	☐	Have you had the BCG (tuberculosis) vaccine?
5.	☐	☐	☐	Have you been in contact with someone who has TB disease? If so, who and when? _____
6.	☐	☐	☐	Have you ever used injection drugs?
7.	☐	☐	☐	Do you have HIV/AIDS, diabetes, or severe kidney disease?
8.	☐	☐	☐	Do you have any diseases that could affect your immune system, such as cancer or leukemia?
9.	☐	☐	☐	Have you been vaccinated with a live virus vaccine in the past four (4) to six (6) weeks? If so, what was/were the vaccine(s)? _____
10.	☐	☐	☐	Can you return in 48 hours to have to TB skin test results read?

11. What is your reason for testing today? If employment / school, list name: _____

12. In what country were you born? If not the U.S., when did you come to the U.S.? _____

CONSENT TO TESTING

I agree that I have received information about the TB skin test and that I have had the chance to ask questions, which were answered to my satisfaction. I agree to return in 48 hours to have the test results read. I understand the risks and benefits of the TB skin test, and request that the test be given to me.

_____ _____
Client Signature Date

_____ _____
Reviewing Nurse Signature Date

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