Tuberculosis Symptom Screening

Please complete the following question:

Do you have a history of a positive reaction to a TB skin test? Yes No

When was your last chest x-ray? _________________ Were results normal? Yes No

Have you been treated with antibiotics to prevent the development of active TB? Yes No

If yes, how long did you take the medication? ______________

Have you ever been diagnosed with active Tuberculosis (TB)? Yes No

Have you ever received BCG vaccine? Yes No

Date ______________________________

Do you have any of the following symptoms? Yes No

☐ Persistent cough?
☐ Coughing up blood/phlegm?
☐ History of unexplained night sweats?
☐ Persistent fever?
☐ Recent history of unexplained weakness or weight loss?

Patient Name: _______________________________ G#: __________________________

Student Signature:___________________________ Date: _______________________