Providence St. Joseph Health

TUBERCULOSIS SCREENING QUESTIONNAIRE

Name: _____ **Date of Birth:**_____ **Caregiver ID #:**_____
Last First Middle

☐**Caregiver/Applicant:** ☐ **Volunteer** ☐ **Other:** _____

DO YOU CURRENTLY HAVE SYMPTOMS OF:		**If yes, please explain**:
Productive cough for more than three weeks?	☐Yes ☐No	
Fever associated with cough for more than one week?	☐Yes ☐No	
Blood present in sputum?	☐Yes ☐No	
Unexplained night sweats? (Ex: unrelated to menopause)	☐Yes ☐No	
Unusual fatigue for more than two weeks?	☐Yes ☐No	
Loss of appetite for more than two weeks?	☐Yes ☐No	
Unexplained weight loss of five pounds or more?	☐Yes ☐No	
CURRENT HEALTH STATUS:		**If yes, please explain**:
Do you have an acute viral infection or febrile illness?	☐Yes ☐No	
Have you had a live-virus vaccine in the past six weeks?	☐Yes ☐No	
Are you currently taking steroids (e.g. cortisone or prednisone)?	☐Yes ☐No	
Are you currently undergoing radiation, chemo or immunosuppressive therapy?	☐Yes ☐No	
HISTORY		**If yes, please explain**:
Are you foreign-born?	☐Yes ☐No	Country:
Have you been out of the country in the past six months?	☐Yes ☐No	Country:
Have you ever had a TB skin or blood test	☐Yes ☐No	
Have you ever had a positive reaction to a TB test?	☐Yes ☐No	Date:
Have you had chest x-ay(s) related to a positive TB test?	☐Yes ☐No	Date(s):
Is there anyone in your family with TB?	☐Yes ☐No	Relationship:
Have you ever had close contact with active TB (including health care exposure)?	☐Yes ☐No	
Have you ever been treated with TB medication?	☐Yes ☐No	Duration: Year:
Have you received the BCG vaccine?	☐Yes ☐No	
Do you have any illness which can suppress your immune system?	☐Yes ☐No	
Please note: HIV infection and other medical conditions may cause a TB test to be negative, even when TB infection is present. Persons with HIV infection and certain other medical conditions that may suppress the immune system are at significant risk of progressing to TB disease, if they have TB infection. If you have HIV infection or other medical conditions that may suppress the immune system, discuss your risk of TB with your primary care provider.		

To my knowledge, the above information is correct. I consent for IGRA (TB) blood test, TB skin test, and/or chest x-ray.

Applicant/Caregiver Signature:_____ Date: _____

For Clinic Use Only

Caregiver Health Nurse Review: I have reviewed the above symptoms and recommend:
☐IGRA ☐TST ☐Symptom review only ☐CXR

CHN Name (print):_____Signature:_____Date: _____

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IGRA: Draw Date:_____Review Date:_____IGRA Results: ☐Negative ☐ Positive
IGRA: Draw Date:_____Review Date:_____IGRA Results: ☐Negative ☐ Positive
Follow-up Action: ☐ No further follow up needed CHN Name:_____
CXR ordered; Date:_____ Results: ☐Negative ☐ Positive CHN Name:_____