



ANNUAL TUBERCULOSIS SCREENING QUESTIONNAIRE

Have you ever had a TB skin test? YES NO

If yes was the test positive? YES NO

Has a family member or close contact ever had a positive TB skin test? YES NO

Have you ever been told that you have/had an abnormal chest x-ray? YES NO

Have you traveled outside of the United States in the last year? YES NO

If yes please list the name of the city, country, and approximate dates:

Were you born in the United States? YES NO

If no, please indicate the country where you were born:

In the last 12 months, have you had any of the following symptoms?

A persistent productive cough for 3 or more weeks? YES NO

Coughing up blood? YES NO

Excessive fatigue? YES NO

Excessive night sweats? YES NO

Unexplained, recurrent fevers? YES NO

Unexplained, weight loss? YES NO

Patients Name: _____ Birth Date: _____

Patients Signature: _____ Date: _____

Providers Signature: _____ Date: _____