TB SCREENING QUESTIONNAIRE (optional)

CLIENT_____ DOB:_____ ID #:_____
Last First

1.	Have you recently coughed up blood?	Yes	No
2.	Have you been coughing for more than 2 – 3 weeks?	Yes	No
3.	Have you lost more than 5 lbs in the last 2 months?	Yes	No
4.	Have you had frequent fevers in the last month?	Yes	No
5.	Have you had unusual sweating, especially at night?	Yes	No

- If **"Yes"** to question 1 or **"Yes"** to two-or-more of the other symptoms; go to **Evaluate for Active TB** below
- Other findings ("**Yes**" to one symptom): Refer to medical provider as needed, depending on the severity of the symptom

Have you ever had a TB Test?	Yes	No		
What type?			**What was the result?**	
TB Skin Test	Yes	No	Positive	Negative
TB Blood Test	Yes	No	Positive	Negative

Do you have proof of your TB test*? Yes No

- Previous TB test documentation: Record date and result:
- Copy TB test document for program and client's records

TB test Date

_____ mm

_____IU

_____Spots

*Current, acceptable TB tests are Mantoux TB skin test, QuantiFERON blood test, TSpot blood test

SUMMARY (Check all applicable)

If TB Test is:

____ **Not known/No Previous TB test Done**: Refer clients for TB testing ASAP

____ **Negative (no documentation available)**: Refer client for TB testing ASAP

____ **Negative (documented as done within the last 6 months)**: No TB test needed now

____ **Positive History (no documentation)**: Refer for an evaluation of TB testing ASAP

____ **Positive History (documented, date and size recorded above)**:

Chest x-ray needed UNLESS client presents documented proof of a normal x-ray done within the last 6 months. Copy x-ray report for clinic record and record date here: **X-ray Date_____**

____ **Evaluate for Active TB** (coughing up blood or two-or-more other symptoms): Contact TB Control to discuss situation – (619) 692-5565

Staff completing this form:_____ **Date:**_____