Covenant Health System

Tuberculosis

(Confidential Information)

_____

Printed Name

PLEASE COMPLETE ALL QUESTIONS BELOW

(Please check one)

[ ] New conversion to the TB skin test [ ] Yearly and/or post exposure evaluation

1. Have you been around relatives or friends who have a persistent cough? [ ] Yes [ ] No
2. Have you been out of the country? [ ] Yes [ ] No
3. Have you been in large crowds for an extended period of time? (e.g., family reunions) [ ] Yes [ ] No
4. Have you been exposed to a patient with a persistent cough? [ ] Yes [ ] No
5. Do you remember working with a suspected TB patient? [ ] Yes [ ] No
6. Have you had a productive cough for more than three weeks? [ ] Yes [ ] No
7. Have you had any persistent weight loss without dieting? [ ] Yes [ ] No
8. Have you had a persistent low-grade fever? [ ] Yes [ ] No
9. Have you had or experienced any night sweats? [ ] Yes [ ] No
10. Have you had a loss of appetite? [ ] Yes [ ] No
11. Do you have any swollen glands, usually in the neck? [ ] Yes [ ] No
12. Have you had any recurrent kidney or bladder infections? [ ] Yes [ ] No
13. Have you been coughing up blood? [ ] Yes [ ] No
14. Have you experienced shortness of breath without any exertion? [ ] Yes [ ] No
15. Have you experienced any chest pain? [ ] Yes [ ] No
16. Are you receiving immunosuppressive therapy including radiation, corticosteroids, antimetabolites, alkylating agents, and/or cytotoxic drugs? [ ] Yes [ ] No
17. Have you been ill in the past year? [ ] Yes [ ] No
    If "YES" a) What were your symptoms? _____
    _____
    b) Were you seen by a physician? [ ] Yes [ ] No
    If "YES", who _____
18. Have you had the BCG Vaccine? [ ] Yes [ ] No
    If "YES" a) When? _____
    b) Have you had a TB test since the BCG? [ ] Yes [ ] No
19. Is this your first positive reaction to the TB test? [ ] Yes [ ] No
    If "NO" a) What year did you have a positive reaction? _____
    b) What was the size or measurement? _____
20. Have you taken TB prophylactic medication? [ ] Yes [ ] No
    If "YES" a) When? _____
    b) List treatment and/or _____
    c) Did you experience any side effects? [ ] Yes [ ] No
    d) Did you complete the treatment and/or medication? [ ] Yes [ ] No
21. Have you had active TB? [ ] Yes [ ] No
    If "YES" a) Who diagnosed you? _____
    b) When? _____
    c) List treatment and /or medication received _____
    d) Did you experience any side effects? [ ] Yes [ ] No
    e) Did you complete the treatment and/or medication? [ ] Yes [ ] No
22. Have you gone to the Department of Health for evaluation and/or treatment? [ ] Yes [ ] No
23. When was your last (please give dates):
    a) Chest x-ray _____
    Were results positive for TB? [ ] Yes [ ] No [ ] Unknown
    b) Sputum _____
    Were results positive for TB? [ ] Yes [ ] No [ ] Unknown

_____ _____

Signature **Date**