Drug Allergies	**N**	**Y**
Food Allergies	**N**	**Y**
Environmental Allergies	**N**	**Y**
Pregnant	**N**	**Y**

TUBERCULOSIS (TB) ASSESSMENT/CLEARANCE
NEW and PREVIOUSLY TB SKIN TEST POSITIVE INDIVIDUALS

Name_____ Birth Date_____ Today's Date_____

Birth Country_____ Current Country of Residence_____ Years in Current Country_____

Previous TB skin test (TST) WITH documentation: No/Unknown OR Yes Date_____ Result: Neg Pos

Previous Positive TST WITHOUT documentation: No/Unknown OR Yes Date_____ Result: Neg Pos

Quantaferon Gold Test Date_____ Result_____

History of treatment of TB infection or disease: No/Unknown OR Yes Treatment Dates:_____

TB Signs/Symptoms Review:
Do you have any of these symptoms?

Fever N Y Chills N Y Night Sweats N Y
Cough N Y Productive Cough N Y Coughing up blood N Y
Weight Loss (≥10%) N Y
Enlarged cervical lymph nodes N Y

Other: _____

History of prior exposure to someone with TB disease: No/Unknown OR Yes Date_____

Exposure during medical procedure: No/Unknown OR Yes Date_____

Exposure in congregate (group) setting: No/Unknown OR Yes Date_____

Exposure in household of person with TB disease: No/Unknown OR Yes Date_____

History that may increase chance of prior exposure to someone with TB disease:

N	Y	Residence or travel in country where TB is common (Mexico, Latin America, Caribbean, Africa, Eastern Europe, or Asia)	Place/Dates:_____
N	Y	Resident or employee of correctional facility	Place/Dates:_____
N	Y	Resident or employee of homeless shelter	Place/Dates:_____
N	Y	Resident or volunteer in disaster shelter	Place/Dates:_____
N	Y	Resident of long term care facility	Place/Dates:_____
N	Y	Health care worker	Place/Dates:_____
N	Y	Injection drug use	Place/Dates:_____

REFERRAL

Chest x-ray/Date:_____ Results:_____ CXR Report Must be Attached to this form

Patient Cleared for TB, May Participate in Health Care Agency Clinicals: NO YES

Comments:_____

Health-Care Provider Signature/Title: _____

Health-Care Provider Printed Name/Title:_____

Office Address:_____ Office Phone #:_____