



# Tuberculosis Screening Questionnaire

PATIENT'S FIRST AND LAST NAME

DATE

Thank you for taking the time to answer the following questions in preparation for your Tuberculosis Exam.		
1. Have you or anyone you see regularly been diagnosed or suspected of being sick with active tuberculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Do you have family members of frequent visitors who were born in high TB prevalence countries (Asia, Africa, Latin America, Eastern Europe)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Were you born in, or do you travel to high TB prevalence countries (Asia, Africa, Latin America, Eastern Europe)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Do you live in out-of-home placements ( such as foster care or residential facilities )?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Do you have HIV infection or other immunosuppressive conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Do you live with someone with HIV seropositivity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Do you live or frequently visit with persons who have been incarcerated in the last 5 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Do you live among or are you frequently around individuals who are homeless, migrant workers, users of street drugs, or residents in nursing homes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Do you consume alcoholic beverages?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Do you work in health care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Have you ever had positive TB test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Have you received any vaccinations against TB?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

13. When was your last TB test?