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ANNUAL TB
Symptoms Review

First Name _____ Last Name _____

Date of Birth _____ SSN _____ Date form completed _____

Medical History and Risk Factor Review:

Most recent TB skin test: Year _____ Reading (mm) _____

Read as positive or negative? _____

Since your last TB skin test have you entered a TB isolation room or had exposure to a known case of TB? Yes _____ No _____ Don't know _____
If yes, please specify location _____ Time at location_____

Since your last TB skin test have you lived with or had close contact with someone who has TB disease? Yes _____ No _____ Don't know _____

Since your last TB skin test have you traveled and/or lived overseas?_____
If yes, where? _____ Date _____

Since your last TB skin test have you worked in a prison or homeless shelter? _____

Since your last TB skin test have you had an abnormal CXR? _____
If yes, when and what were the results? _____

Since your last TB skin test have you been told by a health practitioner that your immune system is suppressed or compromised (this may affect the results of your test) _____
HIV infection and other medical conditions may cause a TB skin test to be negative even when TB infection is present.

Sign and Symptom Review:
Since your last TB skin test have you experienced any of the following symptoms for more than three weeks at a time? (Please circle yes or no)

Excessive sweating at night	Yes or No	Hoarseness	Yes or No
Excessive weight loss	Yes or No	Persistent coughing	Yes or No
Coughing up blood	Yes or No	Persistent fever	Yes or No
Excessive fatigue	Yes or No		

Name (print) _____ Date _____

Signature _____