# TB Risk Screening Form

DOH-Collier Tuberculosis Program Office (TB Clinic)
Phone: (239) 252-6007
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## TB Symptoms

Unexplained weight loss greater than 3 weeks? ☐ Yes ☐ No

Fever Greater than 3 days? ☐ Yes ☐ No

Productive cough greater than 3 weeks? ☐ Yes ☐ No

## History of TB/LTBI

Have you ever been tested for TB? ☐ Yes ☐ No ☐ Unknown

If yes, what type of test? ☐ Skin Test ☐ Blood Test ☐ Unknown

When? ________________________________________

What were the results? ☐ Positive ☐ Negative ☐ Unknown Result millimeters:_________

Have you ever taken medication for TB? ☐ Yes ☐ No ☐ Unknown ______________________

If yes, what TB Medication(s)?

☐ Isoniazid ☐ Rifamycin ☐ Ethambutol ☐ Pyrazinamide ☐ Unknown ☐ Other _____________

When? _________________ Where? _______________ How many months taken? ______

Have you ever been told that you have an abnormal chest x-ray consistent with TB?

☐ Yes ☐ No ☐ Unknown

If yes, when were you told? __________________ Where? __________________________

## Risk Factors for Exposure

Have you ever been a contact to an infectious case of TB? ☐ Yes ☐ No

If yes, when were you last around this person? ________________________________

Were you born in a country other than the U.S.? ☐ Yes ☐ No

If yes, what country were you born in? _______________________________________

Date Arrived in U.S.? ___________________________________

Have you ever been incarcerated or worked in a jail or correctional facility? ☐ Yes ☐ No

If yes, ☐ Employee ☐ Inmate

Have you ever been a resident or worked in a long-term residential facility? ☐ Yes ☐ No

If yes, name and location of facility: ______________________________________________

Have you been a resident or worked in a shelter for the homeless? ☐ Yes ☐ No

Have you been a seasonal migrant farm worker? ☐ Yes ☐ No

Have you ever worked as a healthcare worker? ☐ Yes ☐ No

Are you a healthcare worker that routinely provides direct care to patients with pulmonary symptoms?

☐ Yes ☐ No

Have you ever worked in a lab that processes TB specimens? ☐ Yes ☐ No

**Risk Factors for Progression to Disease**

Have you engaged in any of the following: ☐ Client Denies all

☐ Drinking alcohol ☐ Injecting recreational drugs ☐ Using high risk substances

Do you have any of the following medical conditions? (Check all that apply) ☐ Client Denies all

☐ Cancer of the head or neck or lung
☐ Chronic Corticosteroid Treatment
☐ Chronic Immunosuppressive Treatment
☐ End Stage Renal Disease
☐ Diabetes
☐ Gastrectomy/Ileal Bypass
☐ HIV Infection
☐ Leukemia
☐ Lymphoma
☐ More than 10% Below Ideal Body Weight
☐ Organ Transplant
☐ Silica Exposure

Referred to TB Program? ☐ Yes

If yes, Reason for referral: ☐ TB-like Symptoms ☐ Previous Positive ☐ Incomplete Treatment

Additional Comments:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Reasons for Testing (select reason if TB testing (TST/IGRA) is to be performed)

☐ Contact
☐ Suspect/Disease
☐ Source Case Investigation
☐ Refugee
☐ Class A, B1, B2 or B3
☐ Individual Targeted (I.e., healthcare worker, student)
☐ Project Targeted
☐ Immigration
☐ Administrative (I.e., low risk individual; seeking employment; school)