Tuberculosis Risk Assessment Form (Required)

Date: _____ Birth Date: _____ Email: _____

Name (Last, First, Midde) _____

Address: _____ City: _____ State: _____

Zip Code: _____ Country of Origin: _____

History Risk: If any of the items are positive you may be required to complete the TUBERCULOSIS SCREENING/TESTING FORM.

- Have you ever had a positive TB skin test? Please circle your answer. No or Yes

  If the answer is yes, please provide the date and induration of the positive PPD.

  Date: _____ mm Induration: _____

- Have you had a QuantiFERON Tb Gold Test? Please circle your answer. No or Yes
  If the answer is yes, please provide the date of the test. _____
  Please circle if the test results were positive or negative (if you answered Yes). Positive or Negative

- Have you had a T-SPOT Tb Test? Please circle your answer. No or Yes
  If the answer is yes, please provide the date of the test. _____
  Please circle if the test results were positive or negative (if you answered Yes). Positive or Negative

Circle the YES, if any of the below apply. If any of the items have a YES answer you are required to complete the TUBERCULOSIS SCREENING/TESTING FORM.

Current Symptoms: Do you currently have any of the following symptoms below?
Please circle your answer. No or Yes If the answer is YES, circle all that apply.

Persistent cough for more than 3 weeks	YES	Persistent night sweats	YES	Loss of appetite	YES
Fever of chills	YES	Unexplained weight loss	YES	Productive cough with bloody sputum	YES

Exposure Risks: If any of the items have a YES answer you are required to complete the TUBERCULOSIS SCREENING/TESTING FORM.
Have you, within the last 2 years, worked or volunteered (more than 8 hr./week) in the following types of facilities? Please circle your answer. No or Yes

Homeless Shelter	Long-term Care	Residential Facilities for patients with AIDS	Rehab Facility	Prisons	Hospitals, Nursing Homes

- Have you recently come into contact with a person who has Tuberculosis?
  Please circle your answer. No or Yes

- Have you ever used any illegal injected drugs?
  Please circle your answer. No or Yes

Health Risks: If any of the items have a YES answer you are required to complete the TUBERCULOSIS SCREENING/TESTING FORM.

Do you currently have any of the following conditions?
Please circle your answer. No or Yes
If the answer is YES, circle all that apply.

Leukemia, lymphoma, Cancers of head or neck, Underweight or malnourished	YES	Gastrectomy, jejunoileal bypass, chronic malabsorptive conditions	YES	Solid organ transplant (kidney, heart), On dialysis or chronic renal failure	YES
Silicosis, Diabetes, HIV Infection, Chemotherapy	YES	Prolonged corticosteroid therapy or other immunosuppressive disorders	YES	On any TNF antagonist medication (Humira, Embrel or Remicade for RA or Crohn's Disease	YES

Travel Risks: If any of the items have a YES answer you are required to complete the TUBERCULOSIS SCREENING/TESTING FORM.

Have you lived or traveled to any country in the following area of the world for a duration of three months or more within the past five years?
Please circle your answer. No or Yes
If the answer is YES, circle all that apply.

India and other Indian Subcontinent nations	Central America, including Mexico	South Pacific (except Australia, New Zealand)	Middle East (except Egypt, Saudi Arabia, Jordan, Lebanon, UAE)	Cuba, Haiti, Dominican Republic
Asia	Africa	Eastern Europe	South America	Portugal