Tuberculosis Screening

inspire
MEDICAL GROUP OF CALIFORNIA

Patient Name: ______________________ ______________________ ______________________
Last Name First Name Middle

Date of Birth: ______________ **Marital Status:** Single Partnered Married Widowed Divorced Separated

Tuberculosis Risk Questionnaire

1. Were you born outside the USA in one of the following parts of the world: Africa, Asia, Central America,South America, or Eastern Europe? Yes No
2. Have you traveled outside the USA and lived for more than one month in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe? Yes No
3. Do you have a compromised immune system such as from any of the following conditions: HIV/AIDS, organor bone marrow transplantation, diabetes, immunosuppressive medicines (e.g. prednisone, Remicade),leukemia, lymphoma, cancer of the head or neck, gastrectomy or jejeunal bypass, end-stage renal disease (on dialysis), or silicosis? Yes No
4. Have you ever done one of the following: used crack cocaine, injected illegal drugs, worked or resided in jailor prison, worked or resided at a homeless shelter, or worked as a healthcare worker in direct contact with patients? Yes No

Tuberculosis Symptom Questionnaire

Do you currently have any of the following symptoms?

1. Unexplained cough lasting more than 3 weeks? Yes No
2. Unexplained fever lasting more than 3 weeks? Yes No
3. Night sweats (sweating that leaves the bedclothes and sheets wet)? Yes No
4. Shortness of breath? Yes No
5. Chest pain? Yes No
6. Unintentional weight loss? Yes No
7. Unexplained fatigue (very tired for no reason)? Yes No

The above health statement is accurate to the best of my knowledge. I will contact my health care professional and/or the health department if my health status changes.

Signature: ______________________ Date: ______________________

Screening administered by licensed health care professional:

Printed name and location: ______________________

Signature: ______________________ Date: ______________________

*This information must be included in the operator or staff member's medical file, which must be maintained separatelyfrom the operator or staff member's individual personnel file that is kept on site.

Record of Tuberculosis Test

Patient Name: ______________________ ______________________ ______________________
Last Name First Name Middle

Date of Birth: ______________________

Type of Test:

☐ **Tuberculin**

Date Given: ______________________

Date Read: ______________________

Results: MM Reading: ______________________ ☐ Negative ☐ Positive

☐ **Interferon Gamma Release Assay**

Date: ______________________

Results: ______________________

Comments

Signature of Authorized Health Professional: ______________________

Date: ______________________ Location: ______________________