TB Screening and Risk Assessment Form

Applicant Name and Contact information.

Name (Last, First, Full Middle):

Date of Birth:

Full Social Security Number:

Sex (Male or Female):

Cell Phone Number:

Email Address:

Have you been tested for Tuberculosis (TB) in the past 12 months? No

Screening Questions

1. Have you EVER spent more than 30 days in a country with an elevated TB rate? This includes all countries except those in Western Europe, Northern Europe, Canada, Australia, and New Zealand.

   No, I have not been in any country for >30 days (except the ones listed above)

2. Have you had close contact with anyone who had active TB since your last TB test?

   No

3. Do you currently have any of the following symptoms:
   a. ____YES / ____ NO unexplained fever for more than 3 weeks.
   b. ____YES / ____ NO cough for more than 3 weeks with sputum production.
   c. ____YES / ____ NO bloody sputum.
   d. ____YES / ____ NO unintended weight loss >10 pounds.
   e. ____YES / ____ NO drenching night sweats.
   f. ____YES / ____ NO unexplained fatigue for more than 3 weeks.

4. Have you ever been diagnosed with active TB disease?

   No

5. Have you ever been diagnosed with latent TB infection *or* had a positive skin test *or* a positive blood test for TB?

   No, none of these is true for me.

6. Have you been treated with medication for TB *or* for a positive TB test (e.g., taken INH")?

   No

   6a. If YES, what year, with which medication, for how long, and did you complete the treatment course?

7. Do you have a weakened immune system for any reason including organ transplant, recent chemotherapy, poorly controlled diabetes, HIV infection, cancer, or treatment with steroids for more than 1 month, immune-suppressing medications such as a TNF-alpha antagonist or another immune-modulator? (If you are not sure, ask your Occupational Health provider)

No, none of these is true for me.

Submit