ReliableHomeHealth

Last Name	First Name	Middle Name	Date of Birth

Address	City	State	Zip

Home Phone	Cell Phone	Today's Date

TB Screening Questionnaire

CIRCLE ANY OF THE BELOW SYMPTOMS YOU HAVE EXPERIENCED **RECENTLY**

(WITHIN THE PAST 6 MONTHS)

Cough Coughing up Blood Fever Weight Loss Tiredness Night Sweats

Please Answer the Following Questions:

Have you ever had a positive TB skin test or TB blood test?	Yes	No	Don't Know
Have you had a severe reaction to a TB skin test?	Yes	No	Don't Know
Have you ever taken medications for Tuberculosis?	Yes	No	Don't Know
What country were you born in?			
What countries have you lived in?			
Have you had the BCG vaccine? (Not common)	Yes	No	Don't Know
Have you been in contact with someone who has TB disease?	Yes	No	Don't Know
Have you ever used recreational injectable drugs?	Yes	No	Don't Know
Do you have HIV/AIDS?	Yes	No	Don't Know
Do you have any diseases that could affect your immune system such as cancer, leukemia, or other?	Yes	No	Don't Know
Do you have diabetes?	Yes	No	Don't Know
Do you have severe kidney disease?	Yes	No	Don't Know
Are you underweight or do you have a disease which affects how you absorb food and nutrients?	Yes	No	Don't Know
Have you had any intestinal bypass or gastrectomy?	Yes	No	Don't Know
Do you take any prescription medications? If yes, list them below:	Yes	No	Don't Know

Applicant Signature: _____ Date: _____