



Comal County
Office of Public Health

Tuberculosis (TB) Screening Form

Name: _____ DOB: _____ Date: _____

Circle the answer **yes** or **no** to the questions; if any answer is yes, give the approximate date the symptoms started and whether or not you still have them.

Have you had any of the following symptoms in the past year?

- | | | | |
|--|----|------------|------------|
| 1. Productive & prolonged cough for 3 weeks or more | No | Yes | Date _____ |
| 2. Persistent weight loss without dieting | No | Yes | Date _____ |
| 3. Night sweats | No | Yes | Date _____ |
| 4. Coughing up blood | No | Yes | Date _____ |
| 5. Fever of long duration | No | Yes | Date _____ |
| 6. Close (in a small area for 6-8 hours) and recent contact with someone with infectious TB | No | Yes | Date _____ |
| <hr/> | | | |
| 7. Have you recently moved (last 5 years) to the US from a foreign country?
Country _____ | No | Yes | Date _____ |
| 8. Have you traveled (substantial contact/ lived with resident populations) outside the United States for more than 1 week?
Country _____ | No | Yes | Date _____ |
| | | How Long ? | _____ |
| 9. Have you lived with someone that is considered at a high risk for TB (an injection drug user, HIV infected, former prisoner) ? | No | Yes | Date _____ |

Other information if not listed on immunization record:

- Positive TB skin test anytime in the past No Yes Date _____
- History of treatment of TB infection or disease No Yes Date _____
Medication _____
Medication taken for _____ months

Signature of Parent _____

Nurse/Healthcare Worker _____

Date: _____ Refer to Primary Care Provider for evaluation _____

Date: _____ Refer for Tuberculin Skin Test _____