

# TB TEST/HEALTH HISTORY QUESTIONNAIRE

## Advocate Occupational and Employee Health Centers

Name \_\_\_\_\_ SS# \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
(please print)

Facility \_\_\_\_\_ Dept Rotating With \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

**REASON FOR SCREENING** (*Test or Questionnaire*)

- |  |  |   |
|--|--|---|
| <input type="radio"/> Pre-Placement        | <input type="radio"/> Initial Exposure       | <input type="radio"/> Post Exposure Follow-up |
| <input type="radio"/> Annual / Semi-annual | <input type="radio"/> Post Exposure Baseline | <input type="radio"/> Other _____             |

**FIT TESTING** (*for those who have been fit tested for the TB mask*)

Since your last fit test for the TB mask or respirator, check all that apply which may have altered the fit of your mask:

- |  |  |
|--|--|
| <input type="radio"/> New scarring on face (injury or surgery)       | <input type="radio"/> Facial fracture (nose, jaw, cheek) |
| <input type="radio"/> Significant weight loss or gain (over 10 lbs.) | <input type="radio"/> Have obtained dentures             |
| <input type="radio"/> Have grown a beard or mustache                 | <input type="radio"/> Plastic surgery on face            |
| <input type="radio"/> Neurologic deficit (Bell's palsy, stroke)      | <input type="radio"/> No Change                          |

**Rotating Associate Signature** (*required*): \_\_\_\_\_

**PPD TESTING**

Have you taken steroids or chemotherapy in the past 6 weeks?  Yes \_\_\_\_\_  No

People who have the following diseases are considered to have a positive TB skin test if induration is 5 mm or greater in size.

Have you been diagnosed as having any of the diseases listed below? Check all that apply.

- |   |                                     |  |
|---|-------------------------------------|--|
| <input type="radio"/> Diabetes          | <input type="radio"/> Cancer        | <input type="radio"/> Alcoholism             |
| <input type="radio"/> Silicosis         | <input type="radio"/> Hodgkin's     | <input type="radio"/> Malabsorption Syndrome |
| <input type="radio"/> Immune deficiency | <input type="radio"/> Renal disease | <input type="radio"/> Recent gastrectomy     |

	Date Applied	Lot#	Applied by	Site	Date Read	(mm induration)	Read by
1 <sup>st</sup> step	____/____/____	_____	_____	o R o L	____/____/____	_____mm	_____
2 <sup>nd</sup>	____/____/____	_____	_____	o R o L	____/____/____	_____mm	_____

***TB test must be read by the Employee Health Center or a TB Liaison 48 to 72 hours after test is placed.***

**TB HEALTH HISTORY QUESTIONS** (*For those with history of positive TB reaction, record the following history but DO NOT RETEST! For follow-up questionnaires only complete section 3.*)

- |     | Yes                   | No                    | Don't Know            |   |
|-----|-----------------------|-----------------------|-----------------------|---|
| 1.  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Have you ever had a positive TB test? If yes, when _____  |
|     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Have you ever been treated with INH to prevent TB? If yes, for how long? _____  |
|     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Have you ever received the BCG vaccine?   |
|     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Have you ever had an abnormal chest x-ray? When? _____  |
| 2.  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Have you ever been told you have Infectious Tuberculosis? If yes, how long ago? _____   |
|     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Have you ever been treated with medication for Infectious TB?   |
|     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Did you take all the TB Medicine until the physician told you that you were finished?   |
| *3. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Do you currently have a cough that has lasted longer than three weeks?  |
|     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Do you cough up blood or mucous?  |
|     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | If yes, have you recently had the mucous you cough up tested for TB?  |
|     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | If yes, were you told it was positive?  |
|     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Have you had a decrease in your appetite? Aren't hungry?  |
|     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Have you lost weight (over 10 pounds) in the last 2 months without trying?  |
|     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Do you have night sweats (need to change the sheets or your clothes because they are wet)?  |
|     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Do you live with or have you been in close contact with someone who was recently diagnosed with TB (e.g. roommate, close friend, relative)? |
|     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Have you been diagnosed with Infectious TB since completing your last TB questionnaire?   |