TB POSITIVE HISTORY QUESTIONNAIRE

Name: _____ Patient ID: _____ DOB: _____

Department: Job:

Last Positive PPD: _____ Administered By:

Test Reason: _____ Date Administered: _____ Recent Converter: ☐

Last Chest X-ray: _____ Results: _____

Treatment: ☐ Medication: _____ Comment: _____

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

	Yes	No
Prolonged Productive cough	☐	☐
Night Sweats	☐	☐
Weight Loss	☐	☐
Fever	☐	☐
Bloody Sputum	☐	☐
Weakness/Fatigue	☐	☐

Date symptoms were first detected: _____

_____ _____ _____

Person Obtaining the Information Signature Date