TB SKIN TEST (TST) AND QUESTIONNAIRE

Name (Print) ________________________________            Department _____________________

1. Have you ever had a positive (reactive) TB skin test? ....................................... □ Yes  □ No

2. Have you ever received INH (Isoniazid)? ........................................................................ □ Yes  □ No

3. Have you ever received BCG? ........................................................................ □ Yes  □ No

4. Recent travel to a foreign country? ........................................................................ □ Yes  □ No

5. Do you have any signs or symptoms of:
   a. Cough lasting longer than 3 weeks, and ...................................................... □ Yes  □ No

   at least one of the following:
   b. Fever ............................................................................................................. □ Yes  □ No
   c. Night sweats ................................................................................................. □ Yes  □ No
   d. Unintentional weight loss? > 10% of body weight ........................................ □ Yes  □ No
   e. Hemoptysis ................................................................................................... □ Yes  □ No
   f. Malaise/fatigue............................................................................................... □ Yes  □ No

   If you answered yes to 2 or more signs and symptoms, a CXR will be required.

6. Do you currently smoke? ..................................................................................... □ Yes  □ No

I, the undersigned, certify that my answers as indicated above are true to the best of my knowledge.

Signature ________________________________            Date __________________________

TB SKIN SCREENING
(Must be read within 48-72 hours)

Step 1/or annual

Date Given___________________ Site____________  By ________________________
Date Read____________________              By ____________________________
Result □ Negative □ Positive ........................................... Induration___________mm

Step 2

Date Given___________________ Site____________  By ________________________
Date Read____________________              By ____________________________
Result: □ Negative □ Positive ...................................... Induration___________mm

Chest X-ray: Date:_________________ Reading:_____________________
Height:_____ Weight:_____ BMI:_____ BP:_____