Castle Medical Center
Adventist Health

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:_____