AMERICAN LUNG ASSOCIATION®
IN INDIANA

# TB Skin Test Patient Questionnaire

*You can type your information directly into this form. You will not be able to save; print before closing.*

*Please check answers. If the question is unclear, ask for an explanation.*

| Yes | No | |
|---|---|---|
| ○ | ○ | Are you pregnant? If yes, due date_____. Need written/verbal consent from healthcare professional. |
| ○ | ○ | Have you ever had a positive TB Skin Test? If yes, where_____ when_____ |
| ○ | ○ | Are you sick today with a severe cold, infection or flu? |
| ○ | ○ | In the past 4-6 weeks, have you had a vaccine for measles, chickenpox, shingles, yellow fever, typhoid or a nasal flu vaccine? If yes, which ones _____ date(s)_____ |
| ○ | ○ | Are you now or have you recently received chemotherapy, radiation or immunosuppressive therapy for a major disease (i.e., cancer)? If yes, please explain _____ |
| ○ | ○ | Have you had a HIV test (test for AIDS)? If yes, when_____ |
| ○ | ○ | Personal history of TB infection or disease? If yes, when _____where treated _____ |
| ○ | ○ | Family history of TB? If yes, who _____when _____ |
| ○ | ○ | If you are foreign born, have you had BCG vaccine? If yes, when?_____ |
| ○ | ○ | Have you had a blood test for TB (i.e., QTF Gold)? If yes, when_____result _____ *(This test requires a doctor's order for a blood draw.)* |
| ○ | ○ | Do you drink alcohol? Amount per day_____ |
| ○ | ○ | Do you smoke cigarettes? How many cigarettes per day _____ |
| ○ | ○ | Do you take any medications? If yes, please list _____ |

**Check all that apply to you:**

- ○ Diabetes
- ○ Organ transplant
- ○ Kidney problems
- ○ HIV infection or AIDS
- ○ Silosis
- ○ Abnormal chest x-ray (old healed TB)
- ○ Injection drug use
- ○ Gastrostomy/Jejunoileal bypass
- ○ Blood disorder (Leukemia/Lymphoma)
- ○ Recent weight loss of >10% of ideal body weight
- ○ Liver problems
- ○ Viral Hepatitis (type _____ )
- ○ Resident or employee of homeless shelter, correctional facility, long-term care or acute care facility, other healthcare facility or group home

Last Name_____ First Name _____ MI__ Parent/Guardian _____
Date of Birth _____Age _____ ○ Male ○ Female Nation of Origin_____
Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated
Race: ○ Caucasian ○ African American ○ Asian Other _____
Ethnicity: ○ Hispanic ○ Non-Hispanic ○ Year arrived in U.S. _____
Local Address _____
City _____ State _____Zipcode _____ County _____
Daytime Phone _____ Email _____
Food/Medication/Latex Allergies_____
Family Physician Name_____Phone _____Location _____
Why do you need this text, x-ray or exam?

1. ○ Work ○ School ○ Volunteer Where?_____ Other _____
2. ○ Contact to active TB case
3. TB symptoms (circle all that apply) ○ Fever ○ Cough ○ Weight loss ○ Night sweats ○ Fatigue ○ Chest pain
   Other symptoms _____