

TB Screening Questionnaire

Patient Last Name: _____ First Name: _____ MI: _____

D.O.B.: ____/____/____ Gender: _____

Instructions: Please circle yes or no for each question.

1. Was your child born in Africa, Asia, Latin America, the Caribbean, or Eastern Europe?
YES / NO
2. Has your child traveled to or lived in Africa, Asia, Latin America, the Caribbean, or Eastern Europe for more than one week? **YES / NO**
3. Has your child been exposed to anyone with TB disease? **YES / NO**
4. Does your child have close contact or live with anyone who was a positive TB skin test?
YES / NO
5. Has your child spend time with anyone during the past 5 years who has been in jail or a shelter, uses illegal drugs, or has HIV? **YES / NO**
6. Has your child ever tested HIV-positive? **YES / NO**
7. Does your child have a household member who was born outside the United States?
YES / NO
8. Does your child have a household member who has traveled outside the United States?
YES / NO

Information Provided By:

Completed by: _____ Relationship _____ Date: _____