Central Montana Health District
Public Health Programs

Annual Tuberculosis Questionnaire

Name:_____ DOB:_____ Date:____/____/_____

Please check **YES** or **NO** in response to the following questions:

Do you have:

1.	Unexplained loss of appetite?	☐ YES	☐ NO
2.	Unexplained weight loss?	☐ YES	☐ NO
3.	Increased fatigue?	☐ YES	☐ NO
4.	Unexplained persistent cough?	☐ YES	☐ NO
5.	Bloody sputum?	☐ YES	☐ NO
6.	Night sweats?	☐ YES	☐ NO
7.	Unexplained low grade fever?	☐ YES	☐ NO
8.	Chest pain?	☐ YES	☐ NO
9.	Shortness of breath?	☐ YES	☐ NO

- **If you answer <u>YES</u> to one or more of the above questions, then evaluation by a medical practitioner <u>is indicated</u>.**

<u>HIGH RISK FACTORS</u>:

1.	Are you a recent contact to an infectious case of tuberculosis?	☐ YES	☐ NO
2.	Are you a recent immigrant (last 5 years) from a country with a high rate of TB? If yes, what country? _____	☐ YES	☐ NO
	➢ (**High prevalence countries**: Africa, Asia – except Japan, Central and South America, Mexico, Eastern Europe, Caribbean, Middle East)	☐ YES	☐ NO
3.	Have you ever had an organ transplant?	☐ YES	☐ NO
4.	Have injected drugs?	☐ YES	☐ NO
5.	Have you ever resided in a jail, prison or nursing home?	☐ YES	☐ NO
6.	Have you ever worked in a lab that processed TB specimens?	☐ YES	☐ NO
7.	Do you have any of the following medical conditions?	☐ YES	☐ NO
	a. Diabetes	☐ YES	☐ NO
	b. Chronic Kidney failure with dialysis	☐ YES	☐ NO
	c. Leukemia	☐ YES	☐ NO
	d. Lymphoma	☐ YES	☐ NO
	e. Cancer of head, neck or lungs	☐ YES	☐ NO
	f. Stomach surgery	☐ YES	☐ NO
	g. Immune problems (diagnosed with HIV disease or taken Prednisone longer than one month?	☐ YES	☐ NO
8.	Have you ever been told you have an abnormal chest x-ray?	☐ YES	☐ NO

- If you answer **YES** to any of these questions, **<u>you are in a high-risk category for contacting TB</u>. THIS DOES <u>NOT</u> mean you have active TB, however, you may want to review the signs and symptoms of TB and seek medical care as needed.**

Client Signature: _____Date:____/____/_____

Office Use:

Date: _____

Reviewed by: _____

- ☐ Follow Up Indicated
  - ☐ Referred to Healthcare Provider-Name of Provider_____
- ☐ No Follow Up Necessary at this time