Comal County

Office of Public Health

Tuberculosis (TB) Screening Form

Name: _____ DOB: _____Grade: _____ Date: _____

Circle the answer **yes** or **no** to the questions; if any answer is yes, give the approximate date the symptoms started and whether or not you still have them.

Have you had any of the following symptoms in the past year?

1. Productive & prolonged cough for 3 weeks or more No Yes Date_____
2. Persistent weight loss without dieting No Yes Date_____
3. Night sweats No Yes Date_____
4. Coughing up blood No Yes Date_____
5. Fever of long duration No Yes Date_____
6. Close (in a small area [car] for 6-8 hours) and recent contact with someone with infectious TB No Yes Date_____
   _____
7. Have you recently moved (last 5 years) to the US from Mexico, Latin America, Caribbean, Africa, Eastern Europe or Asia? No Yes Date_____
   Country_____
8. Have you traveled (substantial contact/ lived with resident populations) from Mexico, Latin America, Caribbean, Africa, Eastern Europe or Asia for more than 3 weeks? No Yes Date_____
   Country_____ How Long? _____
9. Have you lived with someone that is considered at a high risk for TB (an intravenous drug user, HIV infected, former prisoner)? No Yes Date_____

Other information if not listed on immunization record:

- Positive TB skin test anytime in the past No Yes Date_____
- History of treatment of TB infection or disease No Yes Date_____
  Medication_____
  Medication taken for _____months

Signature of Parent_____

Nurse/Healthcare Worker_____

Date: _____ Refer to Primary Care Provider for evaluation_____
Date:_____ Refer for Tuberculin Skin Test_____
Maintain original on file. Revised 5/08