# Bethesda Pediatrics

Tuberculosis Screening

Patient Name: _____ Person Completing Form: _____

Date of Birth: ____/____/____ Today's Date: _____/____/____

| QUESTION | YES | NO |
|---|---|---|
| Has the patient had tuberculosis or had a positive screening test (PPD, TB Quantiferon, or T-Spot)? | | |
| Has the patient had HIV, AIDS, any chronic immune disorder, is immune-suppressed due to medication? | | |
| Did the patient had recent close contact with someone with TB? | | |
| Does the patient or close family member work or volunteer in a high risk setting (long term care facility, hospital, and/or shelter)? | | |
| Does the patient have symptoms of TB (persistent cough, fever, night sweats, loss of appetite, weight loss)? | | |
| Was the patient or family member BORN IN, LIVED IN or VISITED FOR MORE THAN 1 MONTH ANYWHERE OVERSEAS? * | | |

* If the answer is yes to last question, please state where and time of stay below:

_____.

_____.

_____.

_____.