Barton
Community Health Center

ANNUAL TUBERCULOSIS SCREENING QUESTIONNAIRE

Have you ever had a TB skin test?	YES	NO
If yes was the test positive?	YES	NO
Has a family member or close contact ever had a positive TB skin test?	YES	NO
Have you ever been told that you have/had an abnormal chest x-ray?	YES	NO
Have you traveled outside of the United States in the last year?	YES	NO

If yes please list the name of the city, country, and approximate dates:

_____

_____

Were you born in the United States?	YES	NO

If no, please indicate the country where you were born:

_____

In the last 12 months, have you had any of the following symptoms?

A persistent productive cough for 3 or more weeks?	YES	NO
Coughing up blood?	YES	NO
Excessive fatigue?	YES	NO
Excessive night sweats?	YES	NO
Unexplained, recurrent fevers?	YES	NO
Unexplained, weight loss?	YES	NO

Patients Name: _____ Birth Date: _____

Patients Signature: _____ Date: _____

Providers Signature: _____ Date: _____