Paul Farrow
County Executive

Antwayne M. Robertson
Director
Laura L. Kleber
Deputy Director

Waukesha County

Department of Health and Human Services

TB SCREEN QUESTIONNAIRE

Date	Client Name	DOB	Client ID

Is there a history of tuberculosis in your family? ☐ Yes ☐ No

1. Do you have signs and symptoms of TB, such as persistent cough, coughing or spitting up blood, unintentional weight loss, loss of appetite, fever, chills, night sweats, hoarseness or chest pain?
   ☐ Yes ☐ No
   Please list: ______________________

2. Do you have any of the following socioeconomic risk factors: homeless; living in a shelter or prison/jail; injecting drug; crack user; or immigrant from an area with a high incidence of TB, such as Haiti, Africa, Southeast Asia, South/Central America, or the Caribbean? ☐ Yes ☐ No

3. Have you been around anyone with active TB within the last 90 days? ☐ Yes ☐ No

4. Have you had a TB skin test? ☐ Yes ☐ No
   When was the most recent test? ______________________
   What was the outcome (reading)? ______________________

5. Have you had a chest x-ray within the past three months? ☐ Yes ☐ No

6. Have you had TB diagnosed prior to admission to the program? ☐ Yes ☐ No

7. Have you ever been under treatment for TB? ☐ Yes ☐ No
   If yes, when? ______________________
   How long did you take medication, and did you complete treatment?
   ____

8. Are you currently under treatment for TB at the time of admission to the program? ☐ Yes ☐ No

If you answered “Yes” to 1, 2, or 3 above, please discuss your answer with the person completing your assessment.

Was the client referred for TB screening? ☐ Yes ☐ No
If yes, where was client referred? ______________________

Client’s Signature	Counselor’s Signature	Today’s Date

CLI02-0951, 07/13, 10/16, 09/17

Human Services Center, 514 Riverview Avenue, Waukesha, Wisconsin 53188-3631
Phone: (262) 548-7212 ● Fax: (262) 548-7379 ● TDD: 711
E-mail: hhs@waukeshacounty.gov ● Website: www.waukeshacounty.gov/HHS