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