Latent Tuberculosis Evaluation Form

Date: _____ **Referring Nurse / Staff:** _____ **Clinic / Corrections:** _____

Client's name: _____ **Gender:** [ ] Male [ ] Female
Last First Middle

Date of birth: _____ **Age:** _____ **Country of birth:** _____ **What year came to U. S:** _____

Home address: _____ **City:** _____ **State:** _____ **Zip**: _____

Home phone: _____ **Work phone:** _____ **Cell phone:** _____

Ethnicity: [ ] Hispanic [ ] Non - Hispanic **Language (s):** _____

Race: [ ] Asian [ ] Black [ ] White [ ] American Indian [ ] Native Hawaiian or Pacific Islander

Reason for TB skin test?_____ **Occupation:** _____ **Work hours:** _____

Previous TB skin test: [ ] Yes [ ] No **Results:** _____ **Date tested:** _____ **Documentation Available**: [ ] Yes [ ] No

Current TB skin test: [ ] Yes [ ] No **Positive / Negative:** _____mm **Date read**: _____

QuantiFERON-TB (QTF-TB) test: [ ] Positive [ ] Negative **Date tested:** _____ **Where:** _____

Last chest x-ray: **Where** _____ **When** _____ **Results:**_____

Emergency contact person: _____ **Relationship:** _____ **Phone #:** _____

Health Insurance: [ ] Yes [ ] No **Provider**:_____ **Policy #:** _____

Symptoms

Cough: [ ] Yes [ ] No **Started**: _____
Unexplained weight loss: [ ] Yes [ ] No
Started: _____
How many lbs / kgs lost: _____
NORMAL WEIGHT: _____ **lbs / kgs**
Appetite loss: [ ] Yes [ ] No Started: _____
Fever: [ ] Yes [ ] No Started: _____
Chills: [ ] Yes [ ] No Started: _____
Fatigue: [ ] Yes [ ] No Started: _____
Night sweats: [ ] Yes [ ] No Started: _____
Shortness of breath: [ ] Yes [ ] No Started: _____
Chest pain: [ ] Yes [ ] No Started: _____
Contact to TB? [ ] Yes [ ] Unknown
If **Yes**, who: _____ when: _____

Medical History

Previous TB treatment: [ ] Yes [ ] No **How long?** _____
When? _____ **TB medicine:** _____
Current medication: _____
_____
Medication allergies? _____
Chronic illness or immune problems? [ ] Yes [ ] No
What kind? _____
BCG vaccine? [ ] Yes [ ] No **What age?** _____
Pregnant: [ ] Yes [ ] No [ ] May be, **last day of menstrual period:** _____ **EDD:** _____
Hepatitis? [ ] Yes [ ] No **What type?**
[ ] **Hep. A** [ ] **Hep. B** [ ] **Hep. C** [ ] **Unknown**
TB Education provided? [ ] Yes [ ] No
TB Handouts provided? [ ] Yes [ ] No

Risk Factors

Smoking? [ ] Yes [ ] No Date of last use: _____ How many cigarettes per day? _____
IV drug use? [ ] Yes [ ] No Date of last use: _____ Other drug use? [ ] Yes [ ] No Date of last use: _____
Alcohol / Beer use? [ ] Yes [ ] No Date of last use: _____
HIV Risk: [ ] Denied [ ] Yes Date of last HIV test: _____ [ ] Positive [ ] Negative
History of being in jail or prison? [ ] Yes [ ] No Where: _____ When: _____
Have you worked or volunteered in [ ] health care [ ] corrections [ ] shelters other**:** _____
Extensive travel out of country in last 5 years: [ ] Yes [ ] No Where: _____

Assessment / Plan: _____

_____
_____
_____
_____