



- Anderson Creek Dental Center
- Anderson Creek Medical Center
- Angier Medical Center

- Benhaven Medical Center
- Boone Trail Medical Center
- Mobile Unit (Dental / Medical)

Tuberculosis Screening Form

Name: _____ DOB: _____ Chart #: _____ Date: _____

	<u>YES</u>	<u>NO</u>
Have you ever had a positive TB test?		
If ever a positive TB test, what country, state, county: _____		
Have you had a TB test in the past year? Results: Negative / Positive		
Have you ever received the TB vaccine – BCG?		
Were you born in the USA? Birthplace: _____		
If Not, How many years have you lived in the USA? _____		

SYMPTOMS	DESCRIPTIONS	YES	NO
1. Cough	Cough greater than 3 weeks in duration		
2. Fever	Persistent fever elevations greater than 3 weeks		
3. Night Sweats	Persistent sweating that leaves sheets and bedclothes wet		
4. Coughing up blood	Any blood streaked sputum		
5. SOB / Chest Pain	Presently having shortness of breath or chest pain		
6. Wt Loss / Anorexia	Loss of appetite with unexplained weight loss		

RISK FACTORS	YES	NO
1. Does the patient have a history of Tuberculosis or TB skin test conversion?		
2. Was treatment plan of care completed? Where? _____		
3. Does the patient live with someone who has active TB or HIV/AIDS?		
4. Is patient high risk due to: recurrent pneumonia, age, alcoholism, drug abuse?		
5. Does patient live or work in a hospital, nursing home, shelter, prison, or homeless?		
6. Was the patient born, traveled to, or lived in a high risk country? (Africa, Asia, Caribbean, Latin America, Mexico, South America, or Pacific Islands)		

Findings: _____ **Low Risk for Tuberculosis** _____ **High Risk for Tuberculosis**

Comments / Plan of Care: _____

Completed / Reviewed by: _____

Nurse's Signature: _____ **Provider Signature:** _____