Alaska Tuberculosis Program

TUBERCULOSIS SCREENING QUESTIONNAIRE/ REQUEST FOR CHEST X-RAY INTERPRETATION

Film #: _____ Health Record #: _____

Date of Birth: _____ Age: _____ M ☐ F ☐

Name: _____

Last First Middle Initial

Country of Birth: _____ Race: _____ Weight: _____ kg ☐ lb ☐

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Address: _____ City: _____ State: _____ Zip: _____

(if different from above)

Phone Numbers (Home): _____ (Work): _____ (Cell): _____

Usual Occupation: _____ Employer/School: _____

If a child, parent (or a contact) name: _____

PART 1:

1. Reason(s) for this visit or x-ray: **(Check all that apply)**

☐ TB Case or Suspect

☐ Contact to TB Case (Name): _____ Dates of Exposure: ____/____/____ to ____/____/____

Contact Priority: ☐ High ☐ Medium ☐ Low

☐ Immigration Date of Immigration: ____/____/____ From: (Country) _____

☐ TB Clearance: ☐ School ☐ Job ☐ Other, specify: _____

☐ New Positive TST or IGRA

☐ Other: _____

2. Do you have any of these symptoms?

Fever	Yes ☐	No ☐	Don't Know ☐
Heavy sweats at night	Yes ☐	No ☐	Don't Know ☐
Loss of weight (unintentional)	Yes ☐	No ☐	Don't Know ☐

If "Yes," _____lbs/kg Since when? ____/____/____

Fatigue	Yes ☐	No ☐	Don't Know ☐
Cough	Yes ☐	No ☐	Don't Know ☐

If "Yes," when did you start coughing? ____/____/____ OR how long have you been coughing? _____

Productive Cough	Yes ☐	No ☐	Don't Know ☐
Bloody Cough	Yes ☐	No ☐	Don't Know ☐

List any other symptoms: _____

_____

3. Tuberculin Skin Tests

TST (most recent) Date: ___/_____/_____ Result: _____ mm of induration Negative ☐ Positive ☐

Previous TST Date: ___/_____/_____ Result: _____ mm of induration Negative ☐ Positive ☐

4. IGRA: Date: _/_____/_____ Result: __ Negative ☐ Positive ☐ Indeterminate ☐

5. Last chest x-ray: Date: ___/_____/_____ Result: _____

Note: Please send any available chest x-ray taken within the last 2 years for comparison reading.

6. Baseline Liver Function tests needed: Yes ☐ No ☐ Done: Yes ☐ No ☐ If "Yes," is a copy attached? Yes ☐ No ☐

7. Sputums obtained: Yes ☐ No ☐

Date: _____/_____/_____ Result: ____ Date: ____/____/____ Result: _____ Date: ____/____/_____ Result: _____

PART 2:

8. Have you ever had BCG Vaccine? What Year or Age? _____ Yes ☐ No ☐ Don't Know ☐

9. Have you ever been told you have tuberculosis? Yes ☐ No ☐ Don't Know ☐

10. Have you ever taken medications for tuberculosis disease? Yes ☐ No ☐ Don't Know ☐

11. Have you ever taken medications because of a positive skin test? Yes ☐ No ☐ Don't Know ☐

If "Yes," list the name(s) of medication(s): Dates: _____/_____/_____to_____/_____/_____

_____ Dates: _____/_____/_____to_____/_____/_____

_____ Dates: _____/_____/_____to_____/_____/_____

_____ Dates: _____/_____/_____to_____/_____/_____

12. Was all prescribed medication taken? Yes ☐ No ☐ Don't Know ☐

If "No," why not? _____

13. Do you have any of the following diseases, conditions, or risk factors?

a. HIV/AIDS Yes ☐ No ☐ Don't Know ☐

If "Yes," Diagnosis Date: _____/_____/_____

b. Diabetes Yes ☐ No ☐ Don't Know ☐

c. Lung Disease Yes ☐ No ☐ Don't Know ☐

If "Yes," Specify: _____

d. Any disease that affects the immune system; cancer, leukemia? Yes ☐ No ☐ Don't Know ☐

e. Severe kidney disease Yes ☐ No ☐ Don't Know ☐

f. Hepatitis Yes ☐ No ☐ Don't Know ☐

If "Yes," Specify: _____

g. Use of daily steroids for >1 month Yes ☐ No ☐ Don't Know ☐

h. Stomach surgery Yes ☐ No ☐ Don't Know ☐

i. Use of injecting or non-injecting drugs? Yes ☐ No ☐ Don't Know ☐

j. Foreign born or recent travel to a high burden country Yes ☐ No ☐ Don't Know ☐

If "Yes," Country: _____ Dates of travel: _____/_____/_____

k. Exposure to a person with active disease? Yes ☐ No ☐ Don't Know ☐

14. Do you drink alcohol? Yes ☐ No ☐ If "Yes," how many alcoholic drinks do you drink? Per day:_____Per week: _____

15. Do you smoke? Yes ☐ No ☐ If "Yes," how many cigarettes do you smoke? Per day:____ Per week: _____

16. Do you take any prescription medications including steroids, insulin, birth control pills? Yes ☐ No ☐ Don't Know ☐

If "Yes," please list medications in the **Comments** below.

17. Do you have any allergies? Please list medications in **Comments** below. Yes ☐ No ☐ Don't Know ☐

18. If female, are you pregnant? Yes ☐ No ☐ Don't Know ☐ If "Yes", when are you due to deliver: _____/_____/ _____

19. If female, are you post-partum? Yes ☐ No ☐ If "Yes", when did you deliver: _____/_____/ _____

20. If female, are you breastfeeding? Yes ☐ No ☐ Don't Know ☐

Comments:

Primary health care provider:	Phone:

Interviewer's name:		Date:	Phone:
Address:	City:	State:	Zip

Submit with the chest x-ray to: **AK Tuberculosis Program**
3601 C St, Suite 540
Anchorage, AK 99503

Note: Any x-ray not accompanied by this form will be returned to the submitter.