

# TUBERCULOSIS SCREENING FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

POSITION: Primary \_\_\_\_ Secondary \_\_\_\_ Household member \_\_\_\_

Review the list of symptoms below and mark the appropriate line.

Symptom	Yes	No
Productive cough for more than 3 weeks, and at least one of the following:	_____	_____
Fever	_____	_____
Night sweats	_____	_____
Unintentional weight loss	_____	_____
Coughing up blood	_____	_____
Fatigue	_____	_____

If these symptoms are present they are consistent with pulmonary TB.  
A standard chest x-ray and physical examination are required to rule out active TB.

## CHEST X-RAY

Date Done \_\_\_\_\_ Results: \_\_\_\_\_

Comments: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

SCREENING COMPLETED BY: \_\_\_\_\_

(Please print and include title MD, DO, RN, etc.)