# Tuberculosis Symptom Screening Form

This form can be used to screen persons who have a previous positive tuberculin skin test and a baseline chest X-ray that was negative for active tuberculosis (TB) disease. To comply with Annual TB Re-evaluation requirements in the State of Hawaii, such persons must be screened annually for symptoms consistent with TB.

| | | | |
|---|---|---|---|
| Client Name: | | | DOB: _____/_____/_____ |
| **BASELINE** | TST Placed: _____/_____/_____ | TST Read: _____/_____/_____ | Result: _____ mm |
| | CXR Date: _____/_____/_____ | CXR Result: _____ | |

| **TB Symptom Screening** | | | **Onset and Duration of Symptoms** |
|---|---|---|---|
| 1. Cough for ≥3 weeks duration | ❑ No | ❑ Yes | |
| 2. Coughing up blood | ❑ No | ❑ Yes | |
| 3. Fever | ❑ No | ❑ Yes | |
| 4. Night sweats | ❑ No | ❑ Yes | |
| 6. Unexplained weight loss | ❑ No | ❑ Yes | Amount: |
| 5. Unusual weakness or fatigue | ❑ No | ❑ Yes | |
| NOTE: Refer the client for a chest X-ray to rule out TB if he/she reports having a cough for ≥3 weeks duration and at least one of the other symptoms (#2-#5). | | | |

**TB Symptom Screening Outcome (check one):**

- ❑ Client does not report TB symptoms at this time.
- ❑ Client was referred for chest X-ray to rule out TB.
- ❑ Other: _____

_____ _____

Signature of Health Care Provider (MD, PA, APRN, or RN) Date

_____

Printed Name of Health Care Provider