# Adult TB Risk Assessment and Screening Form

**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **TB Risk Assessment** | **yes** | **no** |
| Were you born in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean or the Middle East?  In what country were you born? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| In the past 5 years, have you lived or traveled in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean or the Middle East for more than one month? |  |  |
| In the last 2 years, have you lived with or spent time with someone who has been sick with TB? |  |  |
| Do you have (or have you had) any of these medical conditions?  Diabetes Kidney disease  HIV infection Colitis  Cancer Stomach or intestine surgery  Rheumatoid arthritis |  |  |
| Are you taking any medications that your doctor said could weaken your immune system or increase your risk for infections? |  |  |
| In the past 1 year, have you injected drugs that your doctor did not prescribe? |  |  |
| Have you ever lived or worked in a prison, jail, homeless shelter or long-term care facility? (example: nursing home, substance abuse treatment, rehabilitation facility) |  |  |

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| **Symptom Screening – At this time, do you have any of these symptoms?** | **yes** | **no** |
| Coughing for more than 2-3 weeks? |  |  |
| Coughing up blood? |  |  |
| Weight loss of more than 10 pounds for no known reason? |  |  |
| Fever of 100°F (or 38°C) for over 2 weeks? |  |  |
| Unusual or heavy sweating at night? |  |  |
| Unusual weakness or extreme fatigue? |  |  |

## If you answer “yes” to any of the questions above, you may be at increased risk for TB infection. Please give this form to your medical provider.