Tuberculosis (TB) Risk Assessment

Please complete this form to help us decide if you fall into a high-risk group that requires a TB skin test.

Name: ____________________________

Date of Birth: ____________________

Please circle YES or NO.

1. Have you been around a person sick with active TB disease? Yes No
2. Have you had an organ transplant? Yes No
3. Within the last 5 years, have you lived in, traveled to or had a visitor from a country where TB is common? If yes, what country? ____________
   Yes No
4. Have you ever injected drugs? Yes No
5. Have you been in jail, prison or a nursing home? Yes No
6. Have you ever worked in a lab that processed TB samples? Yes No
7. Do you have?
   a. Diabetes Yes No
   b. Chronic kidney failure with dialysis Yes No
   c. Cancer of the blood or lymph system Yes No
   e. Cancer of the head, neck, or lungs Yes No
   f. Stomach surgery Yes No
   g. Immune problems (HIV or taken steroids like cortisone for longer than one month) Yes No
8. Are you starting a treatment for arthritis? Yes No
9. Have you ever been told you have an abnormal chest x-ray? Yes No
10. Have you had?
   a. A cough and/or hoarseness lasting more than 3 weeks Yes No
   b. A cough with a lot of mucous or blood Yes No
   c. Fever or night sweats for more than one week Yes No
   d. Weight loss without trying Yes No
   e. Tiredness or weakness Yes No

11. Have you ever had a positive TB skin test? Yes No

If you answered NO to all of these questions, you are not in a high-risk group and do not need a TB skin test.

If you answered YES to any of these questions, you fall into a high-risk group and should have a TB skin test or other tests for TB.

Signature/Title of Person Assessing the Client ____________________________

Date ____________________________

GA DPH TB Unit

Rev. 12/2011