TB QUESTIONNAIRE

Patient Name _____ Date of Birth _____

Today's Date _____

1. Have you ever had TB (Tuberculosis)? ○ Yes ○ No
2. Have you been living with anyone in the past 2 years who has been diagnosed with TB? ○ Yes ○ No
3. Have you had a persistent cough and night sweats for more than 2 weeks? ○ Yes ○ No
4. Have you had a persistent cough and fever for more than 2 weeks? ○ Yes ○ No
5. Have you had a persistent cough and loss of appetite for more than 2 weeks? ○ Yes ○ No
6. Have you been coughing up or spitting up bloody sputum (saliva)? ○ Yes ○ No