 14225 University Ave. Suite 130

Waukee, Iowa 50263

515-252-0000

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**Tuberculosis Screening**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Given: \_\_\_\_\_\_\_\_\_\_ Site: \_\_\_\_\_\_\_\_ Lot Number: \_\_\_\_\_\_\_\_\_ Given By:\_\_\_\_\_\_\_\_\_\_

Date Read: \_\_\_\_\_\_\_\_\_\_\_ Induration \_\_\_\_\_\_\_\_\_\_mm Result:(circle one) POS or NEG

(48–72 hours after time given)

Signature & Title of

Interpreter: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section B**

\*Complete this section *ONLY* if there is a history of positive TB exposure, positive skin test.

Positive TB Exposure or Positive TB Skin Test History

\_\_Previous Positive TB Skin Test Date \_\_/\_\_/\_\_\_\_

\_\_BCG Immunization Date \_\_/\_\_/\_\_\_\_

Have you been treated with TB Medication? \_\_YES \_\_NO

Treatment: \_\_ INH Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Chest X-Ray: \_\_ Positive \_\_ Negative Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SYMPTOM REVIEW

Check the symptoms listed below that you have experienced in the past year or currently have:

\_\_ Persistent cough for more than 2 weeks \_\_Night Sweats

\_\_ Anorexia (loss of appetite) \_\_ Fever \_\_Unexplained weight loss

\_\_Bloody sputum \_\_Production of sputum \_\_ Shortness of breath

\_\_None of the above

**\*Please provide most recent CHEST X-RAY results if completing Section B**\*

Nurses Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office/Clinic Information**

Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_