14225 University Ave. Suite 130
Waukee, Iowa 50263
515-252-0000
www.mysighealth.com

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: _____