



14225 University Ave. Suite 130  
Waukee, Iowa 50263  
515-252-0000  
[www.mysighealth.com](http://www.mysighealth.com)

### Tuberculosis Screening Record

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date Given: \_\_\_\_\_ Time Given: \_\_\_\_\_ am/pm Site: \_\_\_\_\_

Lot Number: \_\_\_\_\_ Nurses Signature: \_\_\_\_\_

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: \_\_\_\_\_