

## TB Questionnaire and Quiz

Name: \_\_\_\_\_ ID No.: \_\_\_\_\_

Date: \_\_\_\_\_ Institute/Center: \_\_\_\_\_ Bldg: \_\_\_\_\_ Room: \_\_\_\_\_

Phone: (W): \_\_\_\_\_ (C): \_\_\_\_\_ (H): \_\_\_\_\_

Current residence (City, State): \_\_\_\_\_

1. Have you been in close contact with a person with infectious tuberculosis (active TB) or enrolled in a TB contact investigation in the past 24 months?

If yes, please give details: \_\_\_\_\_

2. Have had an abnormal chest X-ray in conjunction with an evaluation for tuberculosis?

If yes, please give details: \_\_\_\_\_

3. Do you have any medical conditions or take medications that may alter your immune function (e.g. HIV infection, organ transplant, corticosteroid, or TNF- $\alpha$  antagonist therapy)?

If yes, please give details: \_\_\_\_\_

4. Did you immigrate or repatriate to the U.S. from another country within the past 5 years?

If yes, please give details: \_\_\_\_\_

5. Over the past 2 years, have you traveled outside the U.S. to any foreign countries?

Yes  No

If yes, give details: \_\_\_\_\_

6. Over the past 2 years, have you worked or volunteered in settings where you may have been exposed to (check all that apply)?

recent immigrants

homeless persons

persons using illicit drugs, especially by intravenous injection

residents or employees of nursing homes

residents or employees of correctional facilities or orphanages

immunosuppressed persons, people with HIV

patients in healthcare facilities with an increased risk for TB infection

*Mycobacteria*, especially *M. tuberculosis* such as in a laboratory?

If any selected, give details: \_\_\_\_\_

7. Over the past 2 years, have any close friends or family members had symptoms of active tuberculosis (Please circle all that apply: persistent cough over 2 weeks, unexplained weight loss, fever, night sweats, malaise)?

If selected, give details: \_\_\_\_\_

8. Have you been diagnosed or treated with any of the following (circle all that apply)?
- |                        |  |
|------------------------|--|
| Diabetes mellitus      | Low body weight (10% or less normal body weight) |
| HIV infection          | Head or neck tumor                               |
| Severe kidney disease  | Organ transplant                                 |
| Rheumatoid arthritis   | Weight reduction surgery                         |
| Crohn's disease        | Abnormal chest X-ray                             |
| Corticosteroid therapy | Tuberculosis                                     |
| Substance use disorder |  |

If any selected, give details: \_\_\_\_\_

9. Have been immunized with BCG (bacillus Calmette-Guérin)?    Yes    No

10. Have you had any of the following within the past 12 months?

	<u>Yes</u>	<u>No</u>	<u>Comments</u>
a. Fatigue or general loss of energy lasting two weeks or longer	<input type="checkbox"/>	<input type="checkbox"/>	
b. New, unexplained cough lasting three weeks or longer	<input type="checkbox"/>	<input type="checkbox"/>	
c. Loss of appetite for more than two weeks	<input type="checkbox"/>	<input type="checkbox"/>	
d. Unexplained weight loss of 10 lbs. or more than 10% of your usual body weight	<input type="checkbox"/>	<input type="checkbox"/>	
e. Fever greater than 100° F that lasted for at least two weeks	<input type="checkbox"/>	<input type="checkbox"/>	
f. Night sweats (drenching bed clothes) that lasted for at least one week	<input type="checkbox"/>	<input type="checkbox"/>	
g. Any significant change in your health If yes, please explain:	<input type="checkbox"/>	<input type="checkbox"/>	