



# Alaska Tuberculosis Program

## TUBERCULOSIS SCREENING QUESTIONNAIRE/ REQUEST FOR CHEST X-RAY INTERPRETATION

Film #: \_\_\_\_\_

Health Record #: \_\_\_\_\_

Name: First: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last: \_\_\_\_\_ Weight: \_\_\_\_\_ pounds

Date of Birth: (month/day/year) \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ M  F  Pregnant? Yes  No

Race: \_\_\_\_\_ Country of Birth: \_\_\_\_\_ Immigration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
(If different)

Phone Numbers: (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell): \_\_\_\_\_

Usual occupation: \_\_\_\_\_ Employer/School: \_\_\_\_\_

If a child, parent (or a contact) name: \_\_\_\_\_

### PART 1:

#### 1. Reason(s) for this visit or x-ray: (Check all that apply)

- TB Case or Suspect  New positive TST or IGRA
- Contact to TB Case (Name): \_\_\_\_\_ Dates of Exposure: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
Contact Priority:  High  Medium  Low
- Immigration: From: (Country) \_\_\_\_\_
- TB clearance:  School  Job  Other Specify: \_\_\_\_\_
- Other: \_\_\_\_\_

#### 2. Do you have any of these symptoms?

- |                              |                                    |                              |                             |                                     |
|------------------------------|------------------------------------|------------------------------|-----------------------------|-------------------------------------|
| <b>Fever</b>                 | if yes, onset date: ____/____/____ | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| <b>Heavy sweats at night</b> | if yes, onset date: ____/____/____ | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| <b>Recent Weight Loss</b>    | if yes, how much: _____pounds      | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| <b>Fatigue</b>               |                                    | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| <b>Cough</b>                 | if yes, onset date: ____/____/____ | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| <b>Productive cough</b>      |                                    | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| <b>Bloody cough</b>          |                                    | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |

List any other symptoms: \_\_\_\_\_

#### 3. Tuberculin skin tests:

TST(most recent) Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_\_ mm of induration Negative  Positive

Previous TST Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_\_ mm of induration Negative  Positive

4. IGRA: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: (TB Ag-Nil) \_\_\_\_\_ Negative  Positive  Indeterminate

5. Last chest x-ray Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_\_

**Note: Please send any available chest x-ray taken within the last 2 years for comparison reading.**

6. Baseline Liver Function tests needed: Yes  No  Done: Yes  No  If "Yes," is a copy attached? Yes  No

7. Sputa are usually not needed if no symptoms. Sputum obtained: Yes  No   
Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_\_

**PART 2:**

- 8. Have you ever been told you have tuberculosis?
- 9. Have you ever taken medications for active tuberculosis disease?
- 10. Have you ever taken medications because of a positive skin test?

Yes  No  Don't Know   
 Yes  No  Don't Know   
 Yes  No  Don't Know

If "Yes," list the name(s) of medication(s): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Dates: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Dates: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Dates: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Dates: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

- 11. Was all of prescribed medication taken? Yes  No

If "No," why not? \_\_\_\_\_

- 12. Do you have any of the following diseases, conditions, or risk factors?

- a) HIV/AIDS if yes, date of diagnosis \_\_\_\_\_
- b) Diabetes
- c) Lung Disease if yes, type: \_\_\_\_\_
- d) Any disease that affects the immune system, cancer or leukemia
- e) Kidney disease if yes, type: \_\_\_\_\_
- f) Hepatitis if yes, type: \_\_\_\_\_
- g) Current use of daily steroids for more than 1 month
- h) Stomach surgery if yes, type: \_\_\_\_\_
- i) Use of illegal drugs if yes, type: \_\_\_\_\_
- j) Foreign born?
- k) International travel if yes, where/dates: \_\_\_\_\_

Yes  No  Don't Know   
 Yes  No  Don't Know

- 13. Do you drink alcohol? Yes  No  If "yes," how many drinks...

Per day: \_\_\_\_\_ Per week: \_\_\_\_\_

- 14. Do you smoke? Yes  No  If "yes," how many cigarettes...

Per day: \_\_\_\_\_ Per week: \_\_\_\_\_

- 15. Do you take any prescription medications?  
 (Please list medications in **Comments** below)

Yes  No  Don't Know

- 16. Do you have any allergies?  
 (Please list allergies in **Comments** below)

Yes  No  Don't Know

**Comments:**

Primary health care provider:	Phone:
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Interviewer's name:	Date of Interview:	Phone:
Interviewer's Employer:		
Address:	City:	State: Zip:

Urgency of this request: Routine  Urgent

if urgent, please explain: \_\_\_\_\_

Submit with the chest x-ray to: **AK Tuberculosis Program**  
 3601 C Street Suite 540  
 Anchorage, AK 99503

**Note: Any x-ray not accompanied by this form will be returned to the submitter. Thank you.**