Alaska Tuberculosis Program

TUBERCULOSIS SCREENING QUESTIONNAIRE/ REQUEST FOR CHEST X-RAY INTERPRETATION

Film #:_____ Health Record #: _____

Date of Birth:_____ Age:_____ M☐ F☐

Name: _____
Last First Middle Initial

Country of Birth:_____ Race:_____ Weight:_____ kg☐ lb☐

Mailing Address:_____ City:_____ State:_____ Zip: _____

Home Address:_____ City:_____ State:_____ Zip: _____
(If different from above)

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: Date of Immigration:_____/____/_____ From: (Country)_____

☐ TB clearance: ☐ School ☐ Job ☐ Other Specify: _____

☐ Other: _____

2. Do you have any of these symptoms?

Fever	Yes ☐	No ☐	Don't Know ☐
Heavy sweats at night	Yes ☐	No ☐	Don't Know ☐
Loss of weight (unintentional)	Yes ☐	No ☐	Don't Know ☐
If "Yes,"_____lbs/kg Since when?_____/____/_____			
Fatigue	Yes ☐	No ☐	Don't Know ☐
Cough	Yes ☐	No ☐	Don't Know ☐
If "Yes," how long have you been coughing?_____/____/_____			
Productive cough	Yes ☐	No ☐	Don't Know ☐
Bloody cough	Yes ☐	No ☐	Don't Know ☐

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: Negative ☐ Positive ☐ Indeterminate☐

5. Have you ever had BCG? Yes ☐ No ☐ Don't Know ☐ Date, if known:____/____/____Comments: _____

6. Last chest x-ray: Date:_____/____/_____ Result: _____

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

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

8. Sputums obtained: Yes ☐ No ☐

Date:_____/____/_____Result:_____ Date:_____/____/_____Result:_____ Date:_____/____/_____Result: _____

PART 2:

1. Have you ever been told you have tuberculosis? Yes ☐ No ☐ Don't Know ☐
2. Have you ever taken medications for tuberculosis disease? Yes ☐ No ☐ Don't Know ☐
3. Have you ever taken medications because of a positive skin test? Yes ☐ No ☐ Don't Know ☐

If "Yes," list the name(s) of medication(s):_____ Dates:____/____/____to____/____/____

Dates:____/____/____to____/____/____

Dates:____/____/____to____/____/____

Dates:____/____/____to____/____/____

4. Was all prescribed medication taken? Yes ☐ No ☐

   If "No," why not? _____

5. Do you have any of the following diseases, conditions, or risk factors?
   a. HIV/AIDS Yes ☐ No ☐ Don't Know ☐
      If "Yes," Diagnosis Date: _____/____/_____
   b. Diabetes Yes ☐ No ☐ Don't Know ☐
   c. Lung Disease Yes ☐ No ☐ Don't Know ☐
      If "Yes," Specify: _____
   d. Any disease that affects the immune system; cancer, leukemia Yes ☐ No ☐ Don't Know ☐
   e. Severe kidney disease Yes ☐ No ☐ Don't Know ☐
   f. Hepatitis Yes ☐ No ☐ Don't Know ☐
      If "Yes," Type: _____
   g. Use of daily steroids for >1 month Yes ☐ No ☐ Don't Know ☐
   h. Stomach surgery Yes ☐ No ☐ Don't Know ☐
   i. Use of injecting or non-injecting drugs Yes ☐ No ☐ Don't Know ☐
   j. Foreign born or recent travel to a high burden country Yes ☐ No ☐ Don't Know ☐
      If "Yes," Country:_____ Dates of Travel: _____
   k. Have you ever had contact with a TB Case Yes ☐ No ☐ Don't Know ☐

6. Do you drink alcohol? Yes ☐ No ☐ If "yes," how many alcoholic drinks do you drink? Per day:_____Per week: _____

7. Do you smoke? Yes ☐ No ☐ If "yes," how many cigarettes do you smoke? Per day:_____Per week: _____

8. Do you take any prescription medications including steroids, Yes ☐ No ☐ Don't Know ☐
   Insulin, or birth control pills? If "Yes," list medications in **Comments** below.

Comments:

Primary health care provider:	Phone:

Interviewer's name:	Date:	Phone:	
Address:	City:	State:	Zip:

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.