Penn Medicine
Lancaster General Health

Tuberculosis (TB) Screening and Risk Assessment Form

Name: ____ Date: ___________________

Position being hired for: _________________________________ Start Date: ______________

1. Do you currently have any of the following symptoms:

    a. Yes No Unexplained fever for more than 3 weeks
    b. Yes No Cough for more than 3 weeks with sputum production
    c. Yes No Bloody Sputum
    d. Yes No Unintended weight loss greater than 10 pounds
    e. Yes No Drenching night sweats
    f. Yes No Unexplained fatigue for more than 3 weeks

2. Have you ever spent more than 30 days in a country with an elevated TB rate? This includes all countries EXCEPT those in Western and North Europe, United States, Canada, Austrailia and New Zealand.
    a. YES—In my life I have spent greater than 30 days in a foreign country other than those listed
    b. NO—I have not been in any country greater than 30 days except for those listed

3. Since your last TB test, have you had close contact with anyone who had active TB?
    YES NO

4. Have you ever been diagnosed with active TB disease?
    YES NO

5. Have you ever been diagnosed with latent TB infection, had a positive skin test, *OR* a positive blood test for TB?
    a. YES—One or more of these is true for me
    b. NO—None of these are true for me

6. Have you ever been treated with medication for TB *OR* for a positive TB test?
    a. YES, Year in which you were treated _________ Medication taken? _____________________
    b. NO

7. Do you have a weakened immune system for any reason (i.e. organ transplant, recent chemotherapy, pooly controlled diabetes, HIV, cancer, treatment with steroids for more than 1 month, treatment with immune suppressing medications)? If unsure, ask provider.
    a. YES—One or more of these is true for me
    b. NO—None of these are true for me

____ ___________________________
Clinical Reviewer Signature Date