

**CU-Boulder Immunization Program
Tuberculosis Information and Screening Form**

Name _____ Date ___ / ___ / ___
Last First MI

SID# _____ Where were you born? USA ___ Other Country _____
Name of Country

Please circle.

1. Have you ever had a **positive** Tuberculosis Skin Test (PPD)? Yes No

2. Have you ever been given **medicine(s)** to prevent or treat active Tuberculosis? Yes No
 If yes, which medicine did you take? _____
 For how long? _____

3. Have you ever had a **BCG** (immunization for Tuberculosis)? Yes No
 If yes, how old were you? _____

4. Have you ever had **close contact** with a person with active Tuberculosis? Yes No

5. Have you ever **worked or lived in** a nursing home, jail, or homeless shelter? Yes No

6. Have you ever **traveled or lived in** Eastern Europe, Asia, Russia, Africa, or Latin America Yes No
 for more than **two months**? If so, where? _____

7. Have you recently had any of the following **symptoms** for no good reason? Yes No
 (Please circle all that apply.)

<i>Night sweats</i>	<i>Fatigue/Tiredness</i>	<i>Fevers</i>	<i>Weight Loss</i>
<i>Poor Appetite</i>	<i>Coughing up blood</i>	<i>Cough for more than 3 weeks</i>	

8. Have you ever been diagnosed with a **chronic medical condition** that may Yes No
 impair your immune system?

I give consent to release my Tuberculosis information to CU-Boulder Immunization Program and Wardenburg Health Center, 119 UCB, Boulder, CO 80309-0119.

Patient's Signature: _____ **Date** _____
(Parent/guardian signature if under 18 years of age)

If you answered "yes" to any of questions 3 – 8, you must have a Tuberculosis Skin Test (PPD).

The following information must be completed by a Physician's office.

- **Tuberculin Skin Test** (Mantoux only; no tine tests):
 Date given: ___/___/___ Date read: ___/___/___
 Result: _____ (Record actual mm of induration, transverse diameter: if no induration, write "O")
 Interpretation (based on mm of induration as well as risk factors): *Positive Negative*
- **Chest x-ray** (required if tuberculin skin test is positive):
 Result: *Normal Abnormal* Date of chest x-ray: ___/___/___

Physician or Nurse Signature: _____ **Date** _____

Address: _____

Telephone Number: _____ Fax Number _____