PRISMA HEALTH

Individual TB Risk Assessment and Symptom Evaluation

Name: ______________________ Phone: ______________________

Last 5 digits of your SSN: ______________________ DOB: ______________________

Please select the appropriate response to the following statements.
Healthcare personnel should be considered at increased risk for TB if any of the following statements are marked "Yes."

1. Temporary or permanent residence of ≥ 1 month in a country with high TB rate (any country other than the United States, Canada, Australia, New Zealand, and those in Northern Europe or Western Europe).	YES	NO
2. Current or planned immunosuppression, including HIV infection, organ transplant, treatment with TNF-alpha antagonist, chronic steroids (equivalent of prednisone ≥ 15 mg/day for ≥ 1 month) or other immunosuppressive medication.	YES	NO
3. Close contact with someone who has had infectious TB disease since the last TB test.	YES	NO

From the symptom list below, select "yes" or "no" indicating whether you have:

1. Bad cough that lasts 3 weeks or longer	YES	NO
2. Chest pain	YES	NO
3. Coughing up blood or sputum	YES	NO
4. Night sweats	YES	NO
5. Unexplained weight loss	YES	NO
6. Weakness or fatigue	YES	NO
7. Fever or chills	YES	NO
8. Loss of appetite	YES	NO

The information provided is true to the best of my knowledge and belief.

______________________ Signature

______________________ Date

Updated 10.16.19