Insert Logo Here

Patient Label

TB Clinic Initial Health Assessment/History/Exam

Date of History | Time of History | Primary Care Provider | Phone Number of Primary Care Provider

DOB _____ ❑ M ❑ F Race _____ Ethnicity _____

PLEASE MARK: (+) If History is Positive (-) If History is Negative

Eye Exam: OD _____ OS _____ OU _____ ISHIHARA _____

SIGNS & SYMPTOMS OF TB	+/-	DATE OF ONSET	COMMENTS
Cough			
Weight Loss			Today's Wt. _____ Est. Wt. 3 mo. ago _____
Fever/Chills			Temperature _____ Blood Pressure _____ / _____
Shortness of Breath			
Chest Pain			
Hemoptysis			
Loss of Appetite			
Night Sweats			
Fatigue			
Swelling of Lymph Node(s)			

Chief Complaint: _____

Other Signs and Symptoms: _____

TUBERCULOSIS HISTORY	+/-	COMMENTS	TUBERCULOSIS HISTORY
History of BCG		Date(s):	For Bladder Cancer Treatment? ☐ Yes ☐ No
Prior TST Skin Test		Date:	Result (mm): Date: Result (mm):
Prior T-Spot/QuantiFERON		Date:	Result (+/-):
Prior Chest X-Ray		Date:	Result:
Prior Treatment of TB		Date:	Location: Length of Tx:
Prior Treatment of LTBI		Date:	Location: Length of Tx:
Family History of TB		Date:	Relationship to Patient:
Contact to TB Case		Date:	Where? Source Case? Source Case Susceptibility Pattern?

TB MEDICATIONS	START DATE	DOSAGE/SCHEDULE	STOP DATE	PRESCRIBING PROVIDER
RIF				
INH				
PZA				
EMB				
SM				
B_6				
Multi Vitamin				

Signature of Person Taking History _____ Date: _____

Patient Label

MEDICAL HISTORY	+/-	COMMENTS	MEDICAL HISTORY	+/-	COMMENTS
Allergies			Diabetes		
Mental Illness/ developmental delays			HIV/STD		If HIV+, CD4 count: Date: _____
Respiratory Problems (Antibiotic Use?)			Liver Disease/Hepatitis		☐ Hep B ☐ Hep C
Silicosis/Asbestosis			Autoimmune		
Thyroid			Renal Disease		
Corticosteroids		Dose, if receiving : _____ _____	Arthritis/Gout/Joint Pain		Use of: ❑ Remicade ❑ HUMIRA ❑ Enbrel Dates taken: _____
Organ Transplant			Vision/Hearing Disorder		
GI/Gastrectomy or jejunoileal bypass			Chronic Malabsorption Syndrome		
Weight at least 10% less than ideal body weight			Cancer		
Contraception/LMP			Gyn/Pregnancy		
Post-Partum			Breast Feeding		
Hypertension/CVA			Heart Disease/PVD		
Neurological Seizures			Heartburn/Reflux		
Numbness/tingling/burning of extremities			LEP		Translator:

Other Medical History:

SOCIAL HISTORY	+/-	COMMENTS	ADDITIONAL COMMENTS
Foreign Birth		If Foreign-born: Country _____ Mo/Day/Yr Entry US _____	**If Pediatric TB Case/Suspect (< 15 years old):** Country of Birth for primary guardian(s) _____ Patient lived outside US for > 3 months ❑ Yes ❑ No
Foreign Travel or Residence		Country/Year _____	**Locating Info:**
HIV/AIDS Risk		HIV Test provided: ❑ Yes ❑ No: Explain _____ ❑ Deferred (must be offered by (2nd visit)	**Long-Term Care:** ❑ Nsg. Home ❑ Hospital-Based ❑ Residential ❑ Mental Health Res. ❑ Alcohol/Drug Treatment ❑ Other ❑ Refugee camp
Children in the Home < 5 y/o		How many _____ Ages _____	**Comments:**
Alcohol Abuse		# Drinks per Week _____	**Comments:**
Drug Abuse		❑ Non-injecting ❑ Injecting	**Incarceration**: ❑ Fed. Prison ❑ State Prison ❑ Local Jail ❑ ICE ❑ Juvenile Correctional ❑ Other Corr. Unknown Incarceration date: _____
Smoking		Packs per day ____ Times _____ yrs.	**Other tobacco products used** _____
Mental health		❑ No problem ❑ Anxiety ❑ mild/moderate depression	❑ Severe depression ❑ Thoughts of harming self/others Comments _____
Abuse/Neglect/Violence		❑ No fear of harm ❑ Fear of verbal/physical abuse ❑ Daily needs not met	❑ Pressure to have sex ❑ Forced sexual contact ❑ Sex for money or drugs ❑ (sexually active minors only) Age of partner _____
Malnutrition/Diet low in sources of B_6			**Occupation:** ❑ Health Care ❑ Correctional ❑ Migrant/Seasonal ❑ Other Occupation ❑ Child ❑ Student ❑ Homemaker ❑ Retiree ❑ Institutionalized ❑ Not employed in past 24 months ❑ Unknown
Person has been homeless in last 2 years		Homeless shelter _____	**Comments:**

Additional Comments:

Signature of Person Taking History _____ Date: _____

Patient Label

PLEASE MARK: **(+) If History is Positive** **(-) If History is Negative**

PHYSICAL EXAM	NL	ABNORMAL	PHYSICAL EXAM	NL	ABNORMAL
Constitutional			Lymphatic		
HEENT			Skin		
Respiratory			Neurologic		
Cardiovascular			Psychiatric		
Gastrointestinal			Musculoskeletal		

Other Physical Exam Findings:

Chest X-Ray Date Taken: _____

Reading: ❑ Normal ❑ Abnormal: _____

CT Scan: ❑ Normal ❑ Abnormal: _____

Laboratory Results: HIV Date Collected**:** _____ **Result:** + - If positive, CD4 count: _____ and ☐ Referral to Clinic _____

Circle one **Circle one**

Sputum Results: Date Obtained: _____ Smear Result: + - Culture: + - for MTB **Other labs:**

Date Obtained _____ Smear Result: + - Culture: + - for MTB

Date Obtained: _____ Smear Result: + - Culture: + - for MTB

TB Classification ❑ **TB suspect**

❑ 0 No TB exposure, not infected ❑ I TB exposure, no evidence of infection

❑ II Latent TB ❑ III TB, clinically active

❑ IV TB, Clinically inactive

Site of infection: ❑ Pulmonary ❑ Cavity ❑ Non Cavitary ❑ Other

Immigrant/Refugee Classification

❑ B1

❑ B2

❑ Other _____

PLAN: ❑ Isolation ❑ Hotel ❑ Other _____ Return to work/school _____ ❑ Pt refused treatment

Sputum X _____ Date: _____ Additional Sputum X _____ Date: _____ Imaging: _____ Labs: ❑ CMP / Uric Acid ❑ CBC

❑ Provide back-up birth control barrier-method (and/or Refer to Family Planning) ❑ LFTs ❑ Bili ❑ AIC ❑ HIV

❑ Treatment Initiated if so, date: _____ ❑ Treatment not indicated

Contact Investigation: ☐ Initiation Date: _____

Notes:

Follow-up Date: _____

Referral(s): _____ Date(s):_____

Provider's Signature_____ Date:_____