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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **TUBERCULOSIS HISTORY** | **+/-** | **COMMENTS** | **TUBERCULOSIS HISTORY** |
| History of BCG |  | Date(s): |  |
| 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? |

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| **TB MEDICATIONS** | **START DATE** | **DOSAGE/SCHEDULE** | **STOP DATE** | **PRESCRIBING PROVIDER** |
| **RIF** |  |  |  |  |
| **INH** |  |  |  |  |
| **PZA** |  |  |  |  |
| **EMB** |  |  |  |  |
| **SM** |  |  |  |  |
| **B6** |  |  |  |  |
| **Multi Vitamin** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Signature of Person Taking History \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Label

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| **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**:

|  |  |  |  |
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| **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  (2ndvisit) | **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 B6 |  |  | **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**

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| **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:** HIVDate 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

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| **Immigrant/Refugee Classification**  ❑ B1  ❑ B2  ❑ Other \_\_\_\_\_\_\_\_\_\_\_\_  **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 |
| **PLAN:** ❑ Isolation ❑ Hotel ❑ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Return to work/school \_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ Pt refused treatment  Sputum X \_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_ Additional Sputum X \_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_ Labs/Imaging: \_\_\_\_\_\_\_\_\_\_\_ ❑ CMP / Uric Acid ❑ CBC    Notes:    **Contact Investigation**   Initial Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ❑ Reevaluate if symptomatic ❑ Treatment not indicated ❑ Close (discharge) case  Follow-up Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Provider’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_