Tuberculosis Signs and Symptoms Checklist

Client Name: _____ Date: _____

1. Have you ever had a positive skin or blood test for TB?	Yes	No
If yes have you received treatment?	Yes	No
When? _____		
Is there written documentation?	Yes	No
2. Do you smoke?	Yes	No
3. Do you have a cough?	Yes	No
4. Do you cough up anything?	Yes	No
5. Do you cough up blood?	Yes	No
6. Have you lost weight?	Yes	No
7. Has your appetite decreased?	Yes	No
8. Do you have fever or chills?	Yes	No
9. Do you have night sweats?	Yes	No
10. Do you feel unusually tired or weak?	Yes	No
11. Do you have chest pains?	Yes	No
12. Have you been in close contact with someone who has TB?	Yes	No
13. Have you taken prednisone or steroids recently?	Yes	No
14. Are you taking any medications for arthritis?	Yes	No
15. Have you recently been treated for cancer?	Yes	No
16. Do you drink alcohol?	Yes	No
17. Are you pregnant?	Yes	No
18. Are you foreign born?	Yes	No
If so, what country were you born in? _____		
19. How long have you lived in the United States? _____		

Comments: _____

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Nurse Signature: _____ Date: _____