



**RISK FACTORS** (Check all that apply)

<b>MEDICAL RISK</b>		(34) <input type="checkbox"/> Yes, specify <input type="checkbox"/> Immunosuppressive therapy <input type="checkbox"/> Diabetes ( <input type="checkbox"/> Insulin) <input type="checkbox"/> >10% below ideal weight <input type="checkbox"/> TST converter(documented) <input type="checkbox"/> Excessive alcohol use <input type="checkbox"/> Injecting drug use <input type="checkbox"/> Abnormal CXR, c/w old TB <input type="checkbox"/> History of prior TB disease <input type="checkbox"/> Non-injecting drug use <input type="checkbox"/> Dialysis/renal failure <input type="checkbox"/> Gastrectomy/intestinal bypass <input type="checkbox"/> Cancer (Site _____) <input type="checkbox"/> Other _____ <input type="checkbox"/> Silicosis <input type="checkbox"/> <b>NO MEDICAL RISK FOR TB NOTED</b>
<b>POPULATION RISK</b>	(within past year of Dx)	(35) <input type="checkbox"/> Yes, specify <input type="checkbox"/> Homeless shelter resident <input type="checkbox"/> Child exposed to high risk adult <input type="checkbox"/> Migratory agricultural worker <input type="checkbox"/> Health care employee <input type="checkbox"/> Long-term care facility resident <input type="checkbox"/> Homeless not residing in shelter <input type="checkbox"/> Foreign-born in U.S. <5 years <input type="checkbox"/> Marginally housed <input type="checkbox"/> Homeless shelter employee <input type="checkbox"/> Long-term care facility employee <input type="checkbox"/> Prison/jail/juvenile hall inmate <input type="checkbox"/> Prison/jail employee <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>NO POPULATION RISK FOR TB NOTED</b>
<b>HIV RISK</b>		(36) <input type="checkbox"/> Yes, specify <input type="checkbox"/> Child of mother infected or at risk <input type="checkbox"/> Hemophilia <input type="checkbox"/> Unprotected sexual contact and/or multiple sexual partners <input type="checkbox"/> Men having sex with men <input type="checkbox"/> Blood transfusion between 1980-1985 <input type="checkbox"/> Other: _____ <input type="checkbox"/> <b>NO HIV RISK FACTORS REPORTED</b>
		(37) Were HIV services and materials offered? <input type="checkbox"/> Yes <input type="checkbox"/> No
		(38) Highest risk (< 6 years of age, at risk for HIV infection and/ or immunocompromised) <input type="checkbox"/> Yes <input type="checkbox"/> No

**CURRENT TB SYMPTOMS** (Check all that apply)

(39) TB symptoms reviewed?	<input type="checkbox"/> Yes, date <input type="checkbox"/>	<input type="checkbox"/> No
(40) Symptoms	<input type="checkbox"/> Yes, type of symptom(s) <input type="checkbox"/> Cough <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Night sweats <input type="checkbox"/> Weight loss <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Persistent fatigue/malaise <input type="checkbox"/> Hoarseness <input type="checkbox"/> Chest pain <input type="checkbox"/> Other: _____ Date of symptom onset: ____/____/____	
	<input type="checkbox"/> <b>NO TB SYMPTOMS REPORTED</b>	

**MANTOUX TUBERCULIN SKIN TEST (TST)**

(If no documentation of prior positive TST is available, a TST must be done)

(41) Documented prior TST <input type="checkbox"/> No					
		<input type="checkbox"/> Yes, date <input type="checkbox"/>	Result <input type="checkbox"/> <input type="checkbox"/> (mm)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
(42) Documented prior completion of LTBI treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes, date <input type="checkbox"/>					
(43) Received BCG vaccination? <input type="checkbox"/> No <input type="checkbox"/> Yes, date <input type="checkbox"/>					
(44) Documented history of TB disease? <input type="checkbox"/> No <input type="checkbox"/> Yes, date <input type="checkbox"/>					
(45) Current TST Information (related to current contact investigation)					
Was a TST done?					
<input type="checkbox"/> No, specify reason: <input type="checkbox"/> Refused <input type="checkbox"/> Prior Documented +TST <input type="checkbox"/> Other: _____					
<input type="checkbox"/> Yes	Date TST Given	Date TST Read	Result (mm)	Retest Required	Retest Date
1st TST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
2nd TST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
3rd TST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>



