Sarah Bush Lincoln

Last name:_____ First:_____ Middle Initial: _____ Date: _____

Date of Birth: _____ E #: _____ Gender: _____

Cell Phone Number:_____ Email Address: _____

Local Address: _____ City: _____ State: _____ Zip Code: _____

Local Contact: Name: _____ Phone Number:_____

1. What is your country of birth? _____
2. What is your country of childhood? _____
3. Arrival Date to USA? _____
4. Have you ever had a positive TB skin test? ☐ Yes ☐ No
5. Have you ever had a positive TB blood test? ☐ Yes ☐ No
6. Have you ever had history of blistering at site of TB skin test? ☐ Yes ☐ No
7. Have you been exposed to someone with active TB? ☐ Yes ☐ No
8. Have you ever taken medication for TB exposure or positive TB test? ☐ Yes ☐ No
9. Have you ever been diagnosed with or taken medication for TB disease? ☐ Yes ☐ No
10. Have you had a live vaccine in the last 28 days? ☐ Yes ☐ No
11. Have you ever received the BCG vaccine? ☐ Yes ☐ No
12. Have you ever had chest x-ray showing previous TB infection or disease? ☐ Yes ☐ No
13. Do you have a history of inadequately treated TB? ☐ Yes ☐ No
14. Do you have any symptoms of TB disease? Check any that apply:
    - ☐ Fatigue
    - ☐ Loss of appetite
    - ☐ Unexplained weight loss
    - ☐ Night sweats
    - ☐ Unexplained fever
    - ☐ Chills
    - ☐ Chest Pain
    - ☐ Productive prolonged cough (coughing up something for three weeks or more)
    - ☐ Coughing up blood
    - ☐ Difficulty breathing (shortness of breath)
    - ☐ Weakness
15. Do you have any of these risk factors? Check any that apply:
    - ☐ Medical condition such as: diabetes, silicosis, cancer, leukemia, lymphoma, kidney disease
    - ☐ Stomach or intestinal bypass surgery, malabsorption syndromes, low body weight, organ transplant
    - ☐ Prolonged therapy with steroids or other immunosuppressive medications
    - ☐ IV drug use
    - ☐ Resided in, volunteered in or worked in high-risk settings such as prisons, homeless shelters, healthcare facilities, etc.
    - ☐ General anesthesia within the past 9 months
    - ☐ HIV Infection
    - ☐ Spent two months or greater in other countries besides US and country of birth/childhood: list country or countries:

_____

_____ _____ _____

Patient Signature Date Time

Complete form, print, sign/date/time and fax to EIU Medical Clinic at 217-581-8541.

TUBERCULOSIS (TB) SCREENING FORM
EIU MEDICAL CLINIC

Clinic Scan to: Patient Questionnaire/TB Screen Form