Redpoint MEDICAL PSC

TB SCREENING QUESTIONNAIRE

NAME: _____ DOB (month/day/year): _____

You must return in 48 to 72 hours for medical staff to interpret your results. Will this time frame be a problem?	**YES**	**NO**	
Have you ever had a positive TB skin test?	**YES**	**NO**	**Don't know**
If yes, did you have a Chest X-Ray?	**YES**	**NO**	**Don't know**
If yes, were you treated with medication?	**YES**	**NO**	**Don't know**
Have you ever had a severe reaction to a TB skin test?	**YES**	**NO**	**Don't know**
Were you born outside of the United States?	**YES**	**NO**	**Don't know**
Have you had the BCG vaccine?	**YES**	**NO**	**Don't know**
Have you been in contact with someone who had TB disease?	**YES**	**NO**	**Don't know**
Have you ever used injection drugs?	**YES**	**NO**	**Don't know**
Do you have HIV/AIDS?	**YES**	**NO**	**Don't know**
Do you have any diseases that could affect your immune system such as cancer, leukemia or other?	**YES**	**NO**	**Don't know**
Have you had any LIVE vaccines in the past 30 days? (Varicella, Shingles, MMR, Yellow Fever)	**YES**	**NO**	**Don't know**

My signature below certifies that the information I have provided is correct to the best of my knowledge. I will not hold Redpoint Medical nor its medical provider(s) or employee(s) responsible for any errors or omissions that I may have made in completing this form.

_____ _____

PATIENT SIGNATURE TODAY'S DATE