CAPITAL HEALTH CENTER FOR WOMEN'S HEALTH TUBERCULOSIS SKIN TEST WORKSHEET



Name: Date of Birth	n:/_	/
Address:		
Telephone #:		
·	VEC	NIO
Have you ever been diagnosed with tuberculosis?	YES	NO
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Have you ever had a positive skin test (PPD) for exposure to tuberculosis?		
In the last 5 years have you lived or traveled OUTSIDE of the US for a period longer than 1 month?		
Have you lived in the US for 5 years or less?		
Have you worked, lived, or volunteered in a hospital, homeless shelter, prison, nursing homes, or HIV/AIDS clinic in a capacity where you had contact with patients/residents within the last 5 years?		
Have you had close contact with someone with active tuberculosis or a medically underserved population which is at high-risk for tuberculosis?		
Do you currently have one or more of the following medical conditions listed below ? Check (\checkmark) all that apply.		
Diabetes		
Chronic malabsorption syndromes (i.e. Crohn's or ulcerative colitis)		
☐ Silicosis		
☐ Chronic kidney failure		
Prolonged corticosteroid therapy (e.g. Prednisone 15mg/daily or more for 1 month)		
Leukemia or lymphoma		
☐ IV Drug Use (past or present		
Abnormal chest xray suggestive of old or new tuberculosis		
Cancer of the head, neck, or lung		
Low body weight (Body Mass Index <20)		
Abnormal immune system (e.g. HIV/AIDS, cancer,chemotherapy, organ transplant)		
☐ Gastrectomy/Gastric bypass surgery		
□ Jeiunoileal (intestinal) bypass		
☐ Cigarette smoking, current or past		
TST NOT indicated □ no risk factors □ shaded area (above) "YES" response TST INDICATED		
Manufacturer/Brand Name:		
ot #: Expiration Date:		
ate Administerred: Site:		
WH Staff signture/Title:		
Pate Read: / RESULT: Induration =		mr
WH Staff signture/Title:		
isposition: 🗆 Rx chest xray 🗆 Refer 🗆 Repeat		
:WH Staff signture/Title: Date:	/Tim [,]	e: