Ashland County Health Department

TUBERCULOSIS (TB) SCREENING

Please answer the following questions to determine your risk of tuberculosis infection & the need for TB skin testing (TST).

Name: _____ DOB: _____

Note if any of the RISK FACTORS apply since your last TB skin test:	**YES**	**NO**
Close or prolonged contact with someone with TB Disease	_____	_____
Foreign-born person from high-prevalence area (Africa, Asia, Eastern Europe, South/Central America)	_____	_____
Recent Traveler (within past 5 years) to above listed countries	_____	_____
Chest x-ray suggestive of inactive or past TB	_____	_____
Resident or employee of high-risk congregate setting (prison, LTC facility, hospital, homeless shelter)	_____	_____
Chronic immunosuppression from prolonged corticosteroid or prednisone use or other immunosuppressive therapy	_____	_____
Injection drug user/substance abuse (alcohol/cocaine)	_____	_____
Any of the following medical conditions: diabetes mellitus, silicosis, cancer of head or neck, Hodgkin's disease, leukemia, end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, organ transplant recipient, HIV infection	_____	_____
Health care workers who serve high-risk clients	_____	_____
Children exposed to adults in above high-risk categories	_____	_____
Symptoms of TB (bad cough for more than two (2) weeks, coughing up blood, persistent fever, excessive weight loss or fatigue, night sweats)	_____	_____

_____ _____

Signature of patient / parent / guardian Date

Please return this form to your employer or school.

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