NAME (Please Print): ____________________ Date: ___________

Tuberculosis Screening Questionnaire (please circle Y or N)

1. Have you ever had a TB skin test? Y N If yes, when? _________
   Results: ______________
2. Have you traveled outside the USA for a total of one week or longer? Y N
   If yes, where and when? _______________________________________
3. Have you been in contact with anybody who has TB? Y N
   If yes, relationship: _____________
4. Have you been in contact with anybody who has taken medicine for TB? Y N
   If yes, relationship: ______________
5. Have you been in contact with anyone living in a migrant camp?
   Y N If yes, relationship: _____________
6. Are you, or is anyone in your household experiencing a prolonged, productive cough?
   Y N
7. Are you experiencing chest pain? Y N
8. Are you experiencing night sweats? Y N
9. Are you experiencing unexplained weight loss? Y N

Signature: _________________________

Thank you for completing this questionnaire! Any "yes" answers may require follow-up with a TB symptom screening risk assessment and two step baseline TB skin test or single Inteferon Gamma Release Assay (IGRA).

Reviewed by: ________________________Title: _______________________________

Family Building Blocks Early Head Start Staff

Date: ___________________

Review Protocol: Intern/Health Coordinator collect completed/signed form and review – Any Y confirm further testing with Center director.