

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.