


Tuberculosis Screening Test

Patient Information	
Full Name:	
Date of Birth:	
Gender:	
Address:	
Contact Number:	
Medical History & Related Questions	
Have you ever had TB before?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been in close contact with someone diagnosed with TB?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a persistent cough lasting more than 3 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you experienced unexplained weight loss recently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any night sweats or fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tests	
Type of Test:	<input type="checkbox"/> Mantoux tuberculin skin test <input type="checkbox"/> Chest X-ray <input type="checkbox"/> Blood Test
Date of Test:	

Findings (with basis of findings)	
Skin Test Reaction Size:	
Chest X-ray Findings:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (Specify: _____)
Blood Test Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Interpretation	
Based on the findings, the patient:	<input type="checkbox"/> Has active TB <input type="checkbox"/> Has latent TB <input type="checkbox"/> Does not have TB
Overall Interpretation	
Comments/Recommendations:	
Doctor's Verification	
Signature:	
	Date:
Full Name:	