Tuberculosis Screening Test

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

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