TB Questionnaire

Name of Parent/Pregnant Mother:_____ Site _____

Organization administering questionnaire: **Region 7 ESC Head Start** Date _____

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB disease usually have many of the following symptoms: cough for more than two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

A person can have TB germs in his or her body but not have active TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) is used to see if you have been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB.

We need your help to find out if you have been exposed to tuberculosis.

Place a mark in the appropriate box:	Yes	No	Don't Know
TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know: Have you been around anyone with any of these symptoms or problems? or Have you had any of these symptoms or problems? or Have you been around anyone sick with TB?			
Were you born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?			
Have you traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks? If so, specify which country/countries?_____			
To your knowledge, have you spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?			

Have you been tested for TB? Yes___ (if yes, specify date ____/____) No___
Have you ever had a positive TB skin test? Yes___ (if yes, specify date ____/____) No___

(Below is for school/healthcare provider use only) EHS/HS Parent/Pregnant Mother **Signature** _____

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PPD administered Yes___ No___
If yes,
Date administered _____/_____/_____ Date read _____/_____/_____ Result of PPD test _____ mm response

Type of service provider (i.e. school, Health Steps, other clinics) _____

PPD provider _____ _____
signature printed name

Provider phone number _____

City _____ County _____

If positive, referral to healthcare provider Yes___ No___

If yes, name of provider _____

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