Annual/Periodic TB Symptom and Risk Assessment: Established Patient with a Prior Positive TB Test and Incomplete or No Prior Treatment

Patient Name:_____ Birth Date: _____ Medical Record #:_____

TB SYMPTOM REVIEW:
Does patient currently have any of the following symptoms? ☐ Yes ☐ No
☐ cough for more than 3 weeks ☐ coughing up blood ☐ chronic fever
☐ unexplained weight loss ☐ drenching night sweats
IMMEDIATE CHEST X-RAY AND MEDICAL EVALUATION is needed if patient has at least one symptom

TB SCREENING AND TREATMENT HISTORY: *Since patient's last TB risk assessment:*
1. Has *patient complete preventive TB treatment (≥6 months)?* ☐ Yes, regimen_____ ☐ No
2. Has patient had active TB disease? ☐ Yes, date_____ ☐ No
If yes, did patient complete active TB treatment (≥6 months)? ☐ Yes, regimen_____ ☐ No
NEW CHEST X-RAY AND MEDICAL EVALUATION *is NOT needed if the answer is YES to any of the above*

MEDICAL AND EXPOSURE RISKS ASSESSMENT:
1. Does patient have a NEW DIAGNOSIS of any of the following conditions? ☐ Yes ☐ No
☐ HIV ☐ diabetes ☐ cancer ☐ kidney failure
☐ chronic tobacco use

2. Is patient taking any of the following immunosuppressive medications? ☐ Yes ☐ No
☐ prednisone ☐ methotrexate ☐ cyclosporine ☐ chemotherapy for cancer
☐ rheumatoid or psoriatic arthritis/Crohn's disease drugs (e.g., anti-TNFα, other biologic agents)

3. Has patient had any contact to someone with known TB disease of the lung? ☐ Yes ☐ No

4. Does patient have HIV/AIDS? ☐ Yes ☐ No

5. Is patient seeking program (shelter or detox) clearance? ☐ Yes ☐ No

NEW CHEST X-RAY AND MEDICAL EVALUATION for preventive treatment is needed if YES to any of the above

Person completing the form: _____ Date: _____