**TB Risk Assessment**

**Date: _________________**

**Patient Name: _________________________ Date of Birth___________________**

**Do you currently have any of the following symptoms ◯ Yes ◯ No**
**□ prolonged cough >3 weeks □ coughing up blood □ unexplained weight loss**
**□ chronic fever □ drenching night sweats**

**In the past 2 years….**
**Have you had any contact with someone with known TB disease of the lung? □ Yes □ No**
**Spent more than 2 weeks in Asia, Africa, Latin America or Eastern Europe? □ Yes □ No**
**Been in prison or jail? □ Yes □ No**
**Been homeless? □ Yes □ No**
**Injected street drugs? □ Yes □ No**
**Worked with homeless persons, migrant works or drug users? □ Yes □ No**
**Worked as a healthcare worker? □ Yes □ No**

**** TB test is needed if the answer is YES to any of the above questions. Proceed with office protocol at that point. If the answer is NO then no further action is required.**

**Patient Signature_____________________________________**

**Provider Signature______________________________________**