SPECTRA EYE INSTITUTE
9849 W. Thunderbird Boulevard
Sun City, Arizona 85351
623-583-2020

PATIENT TUBERCULOSIS ASSESSMENT QUESTIONNAIRE

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Please complete the following:

_____Yes _____No Have you ever had a positive TB skin test?
_____Yes _____No Have you ever had a chest X-ray to check for TB?
*If "Yes", was chest X-ray ___Positive or ___Negative?
_____Yes _____No Have you ever been medically treated for TB?

Do you currently have any of the following symptoms?

_____Yes _____No 1. Cough lasting longer than two weeks
_____Yes _____No 2. Unexplained fever
_____Yes _____No 3. Night sweats
_____Yes _____No 4. Blood tinged sputum production (coughing up blood)

If you answered YES to any of these questions, please describe symptoms further and the reason for these symptoms. When did the symptoms begin? Have you sought treatment? If yes, what treatment was done?

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_____

Patient Name (Print) _____

Patient Signature_____Date:_____

Reviewed by: _____Date:_____

Action Taken:_____

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