Employee Health
Tuberculosis Assessment Form

Texas Children's Hospital®

Name: _____ Date:_____

Work Location:_____ Department:_____

When was your last TB Assessment? _____ Result: **O** Positive **O** Negative

	Date Applied	Administered by	Site	Date Read	Induration	Read by	Lot#	Expiration Date
1st step			RT LT					
2nd step			RT LT					

IGRA Type	Date Collected	Facility	Date of Result	Result

Only complete section below if your past TB Assessment was positive, otherwise leave blank.

TB Questionnaire for Positive Skin Test Reactors

Have you been experiencing any of the following: (Please check the appropriate response)

	Yes	No
• Low grade fever?	___	___
• Loss of appetite?	___	___
• Increased fatigue?	___	___
• Weakness	___	___
• Unexplained weight loss?	___	___
• Night sweats?	___	___
• Persistent cough?	___	___
• Increased phlegm production	___	___
• Chest pain?	___	___
• Blood-streaked sputum?	___	___

If you answered **Yes** to any of the above, or are newly positive at 10mm:

	Yes	No
• Have you been out of the country within the last year?	___	___
• Do you have a medical condition which would affect your immune system?	___	___
• Have you been in recent close contact with any person who has active Tuberculosis?	___	___
• Have you ever had a chest x-ray that was not normal?	___	___

If you answered **Yes** to any of the questions, please provide details below (dates, illnesses, treatments, etc.)

_____

_____

_____ _____ _____

Signature Printed Name Date

To be completed by Employee Health

Reviewed by _____ Date