TUBERCULOSIS (TB) SYMPTOMATIC SCREENING

Patient History **Tick (√) in the appropriate block or complete where required**				
Have you been diagnosed with TB previously?	**Yes**		**No**	
How many times have you had TB?	**None**	**or state: times**		
When did you last have TB (state the year)?				
How long was the treatment?	**Less than 6 months**	**6 months**	**8 months**	**More than 8 months**
If less than 6 months why?				
Does your work environment increase your risk of infection?	**Yes**		**No**	
Have you ever taken preventative TB treatment (IPT)?	**Yes**		**No**	
If yes to the above, how long were you on treatment and when was preventative treatment completed?				

#	**10 TB screening questions** **Tick (√) in the appropriate block**	**Yes**	**No**
1	Have you been coughing for more than 2 weeks?		
2	Are you HIV positive? If answered Yes Have you been coughing for more than 24 hours?		
3	Mucous production which may occasionally be blood-stained?		
4	Fever for more than 2 weeks?		
5	Very bad night sweats?		
6	Loss of appetite?		
7	Unexplained weight loss of more than 5kgs in a month?		
8	General feeling of illness and tiredness?		
9	Chest pain or difficulty in breathing?		
10	Have you been in contact with someone who you think may have TB?		

* If you answered YES to any one of the above questions please provide us with your full name so that we can contact you OR report to Campus Health Service for diagnostic testing to exclude for TB.