West Virginia Department of Health and Human Resources
Division of Tuberculosis Elimination
TB Risk Assessment

Patient name: _____ Birth date: _____Date:_____

Do you have any of the following symptoms? (Please indicate by circling yes or no to each)

Yes *No* Cough (Longer than 3 weeks)
Yes *No* Fever
Yes *No* Coughing up blood
Yes *No* Loss of weight
Yes *No* Loss of appetite
Yes *No* Night sweats
Yes *No* Fatigue

Were you born in another country? (Please indicate by circling yes or no)

Yes *No* Please indicate the country: _____

Have you? (Please indicate by circling yes or no to all)

Yes *No* Had a recent contact with someone with active TB?
Yes *No* Ever had a TB skin test done?
When_____Where_____ Positive or Negative_____
Yes *No* Ever had a TB blood test done?
When_____Where_____ Positive or Negative_____
Yes *No* Recently or currently been homeless? (Within the past 2 years)
Yes *No* Visited another country for 2 months or more?
Please indicate the country: _____
Yes *No* Lived in another country?
Please indicate the country: _____
Yes *No* Taken the BCG vaccine?
Yes *No* Been treated with BCG for cancer?

Are you? (Please indicate by circling yes or no to all)

Yes *No* A student who is entering the public or private school system and moved to WV within the past 4 months?
Yes *No* New personnel entering the WV school system for the first time?

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Have you had? (Please indicate by circling yes or no to all)

Yes *No* Cancer of the head and/or neck?
Yes *No* Leukemia?
Yes *No* Any other form of cancer?

Do you now have or have you had a history of? (Please indicate by circling yes or no to all)

Yes *No* A diagnosis of HIV?
Yes *No* A known risk for HIV?
Yes *No* Diabetes?
Yes *No* Lung disease such as COPD, Silicosis or black lung?
Yes *No* Kidney disease?
Yes *No* Intestinal bypass surgery?
Yes *No* Gastrectomy surgery?
Yes *No* An impaired immune system?
Yes *No* A disease that requires medications that decrease your immune system?

I am requesting a TB test because: (Please indicate by circling yes or no to each)

Yes *No* My employer requires me to have this test.
Yes *No* My education institution requires me to have this test.
Yes *No* Other reason: _____

Name of Employer or Education Institution: _____
_____

FOR OFFICE USE ONLY

NURSE SIGNATURE:_____ DATE:_____

_____ State TST _____State IGRA _____Private TST_____ Private IGRA _____ CXR _____

DIAGNOSTIC CLINIC _____ Sputum X 3 _____ NO FOLLOW-UP NEEDED _____ LETTER GIVEN_____

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