

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

Do you have any of the following symptoms? (Please indicate all that apply)

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: _____

Are you now or have you ever? (Please indicate all that apply)

Yes	No	Been in close contact with someone with active TB?
Yes	No	Had a positive TB test?
Yes	No	Visited another country for 2 months or more? Please indicate: _____
Yes	No	Lived in another country? Please indicate: _____
Yes	No	Taken the BCG vaccine?
Yes	No	Been a healthcare worker? Please indicate: _____
Yes	No	Lived or worked in a homeless shelter?
Yes	No	Lived or worked in a nursing home?
Yes	No	Been an inmate or worked in a jail/prison?
Yes	No	Lived or worked in a long-term residential facility? Please indicate: _____
Yes	No	Used illegal drugs?
Yes	No	Used alcohol in excess? (More than 1 drink per day)

Do you have? (Please indicate all that apply)

Yes	No	A known risk for HIV?
Yes	No	Diabetes?
Yes	No	Silicosis or black lung?
Yes	No	Cancer of the head and/or neck?
Yes	No	Leukemia?
Yes	No	Any other form of cancer?
Yes	No	Kidney disease?
Yes	No	A history of Intestinal bypass surgery?
Yes	No	A history of Gastrectomy surgery?
Yes	No	An impaired immune system?
Yes	No	A disease that requires medications that decrease your immune system?