



Tuberculosis Skin Testing Client Questionnaire

Florida guidelines for tuberculosis skin testing have changed. Skin testing is now recommended only for groups at high risk to progress from infection to disease. Routine TB skin testing is no longer recommended for students in Florida schools or universities, pregnant women, teachers, school bus drivers, workers at daycare center, food handlers, and certain others. Please complete this form to help us determine if you fall into a high-risk group that requires a tuberculin skin test under the new guidelines.

Please check YES or NO in response to the following questions:

1. Are you a recent contact to an infectious case of tuberculosis? Yes No
2. Have you ever had an organ transplant? Yes No
3. Are you a recent (within the last 5 years) immigrant from a country with a high rate of TB? If yes, what country? _____ Yes No
4. Have you ever injected drugs? Yes No
5. Have you been in jail, prison, or a nursing home? Yes No
6. Have you ever worked in a lab that processed TB specimens? Yes No
7. Do you have any of the following medical conditions?
 - a. Diabetes Yes No
 - b. Chronic kidney failure with dialysis Yes No
 - c. Leukemia Yes No
 - d. Lymphoma Yes No
 - e. Cancer of the head, neck, or lung Yes No
 - f. Stomach surgery Yes No
 - g. Immune problems (Diagnosed with HIV disease or taken Prednisone longer than one month) Yes No
8. Have you ever been told you have an abnormal chest x-ray? Yes No
9. Have you had any of the following symptoms recently?
 - a. Cough and/or hoarseness lasting more than 3 weeks Yes No
 - b. Recent unexplained weight loss Yes No
 - c. Fever or night sweats for more than a week Yes No
 - d. A productive cough or coughed up blood Yes No

If you answered NO to all of these questions, you do not fall into one of the groups that should receive a skin test. This determination is based on current standards provided to the Florida Department of Health and this county from the Centers for Disease Control and Prevention, an agency of the U.S. Government, and endorsed by the American Lung Association of Florida. If you answered YES to any of these questions, you will be further evaluated by a County Health Department Nurse.

Signature/Title of Person Assessing the Client Date

Name: _____

ID#: _____

Date of Birth: _____