# TUBERCULOSIS SYMPTOM AND RISK ASSESSMENT QUESTIONNAIRE

**PLEASE PRINT LEGIBLY**

<table>
<thead>
<tr>
<th>Name: ___________________________</th>
<th>Date of Birth: ______________________</th>
</tr>
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<tbody>
<tr>
<td>Status: Faculty</td>
<td>Staff</td>
</tr>
<tr>
<td>Employer (circle all that apply): IU</td>
<td>IU Health</td>
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</tbody>
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## HISTORY

1. Had any unexplained fever in recent weeks to months? **Y**  **N**
2. Had any drenching sweats in recent weeks to months? **Y**  **N**
3. Had any unexplained coughs in recent weeks to months? **Y**  **N**
4. Had any chest pain in recent weeks to months? **Y**  **N**
5. Had any unexplained weight loss in recent weeks to months? **Y**  **N**
6. Had any known exposure to TB? If YES, when? **Y**  **N**
7. Had an abnormal chest x-ray in the past? **Y**  **N**
8. Provided medical care to others in a country with endemic TB since your last TB test? **Y**  **N**
9. Had a history of immunosuppression, such as an organ transplant, taking immunosuppressive medications or HIV? **Y**  **N**
10. Been on more than 15mg of prednisone for more than one month? **Y**  **N**
11. Moved to the United States within the last five years? If so, where did you live previously? **Y**  **N**
12. Had a history of any of the following: IV drug use, working in a mycobacteriology laboratory, or working as a resident / employee of a high risk setting (e.g. hospital)? **Y**  **N**
13. Had any of the following medical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemia, lymphoma, head or neck cancer, lung cancer, stomach or intestinal surgery or weight loss of more than 10% below ideal body weight? **Y**  **N**

## IF HISTORY OF POSITIVE TB TEST

1. When did you first convert to a + TB skin test or blood test (IGRA)? ________________
2. Did you ever receive treatment for TB? □ Yes □ No If yes, how long? ________________
   What medications? ________________
3. Who followed up your conversion? ________________
4. When was your last chest x-ray? ________________ Results? ________________

Date ________________  
Signature ________________

Date ________________  
Reviewed by: (IU Indianapolis CH Staff)

**Determination (Circle One):** Asymptomatic / Symptomatic