DATE:

Name:
MRN#

Adult Tuberculosis Risk Assessment

1. Have you ever had tuberculosis or been treated for tuberculosis? YES NO

   *If yes, what year? _____

2. Were you born outside the United States? YES NO

   *If yes what country? _____

3. Have you traveled outside the United States? YES NO

   *If YES what country? _____

4. Do you think that you been exposed to anyone with Tuberculosis (TB) disease? YES NO

   *If Yes relation? _____

5. Do you have close contact with a person who has a positive Tuberculosis (TB) skin test or blood test? YES NO

   *If Yes, relation? _____

Adult Immunizations

Have you had any of the following vaccinations?

PCV-13 – Pneumococcal conjugate YES NO Unknown
If yes, when? _____

PPV-23 – Pneumococcal polysaccharide YES NO Unknown
If yes, when? _____

Zostavax - Shingles Vaccine YES NO Unknown
If yes when? _____

T-dap- Whooping cough YES NO Unknown
If yes when? _____

**********SEND TO BE SCANNED**********

For office use only

MA Signature: _____ Date: _____

Provider Signature: _____ Date: _____