DATE:

Name:
MRN#

Adult Tuberculosis Risk Assessment

1. Have you ever had tuberculosis? YES NO

   *If yes, was it transmitted: Maternally Paternally Other: __________

   *If yes, were you treated and 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, what is the relationship with the person? ___________________

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

   *If yes, what is the relationship with the person? ___________________

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: ________________

Revised: 12/20/2016

Location: K:\4000-Clinics\413-ALL\Clinic Letters