



Children's
Health
Partners

TUBERCULOSIS SCREEN QUESTIONNAIRE

Patient's Name: _____ Date: _____

DOB: _____

- | | | |
|---|-----|----|
| 1. Has the child traveled out of the country recently?
a. If yes, where? _____ | Yes | No |
| 2. Has the child been exposed to someone who has
visited from out of the country recently and who
is sick with a cough?
a. If yes, from where? _____ | Yes | No |
| 3. Has the child been exposed to someone with a
chronic cough (more than 1 or 2 months)? | Yes | No |
| 4. Has the child been exposed to someone with
Tuberculosis? | Yes | No |

Dr./Nurse Signature: _____ Date: _____

TB Test Indicated? Yes No