



## Tuberculosis (TB) Test Questionnaire

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

I attest that the following statements are true: Please check "Yes" or "No"

1. Do you have any respiratory problems such as chronic cough or bronchitis? Yes  No
2. Have you ever had a positive Tuberculin (TB) or PPD Test? Yes  No
3. Have you ever been exposed to Tuberculosis (TB)? Yes  No
4. Have you ever had an allergic reaction to the Tuberculin or PPD Test? Yes  No

If any of the above questions are answered "yes," you must consult your doctor or clinic for testing of active TB and have a Chest X-Ray.

By signing below, I authorize Evans Urgent Care to administer a Tuberculin Test (PPD) and release Evans Urgent Care and their personnel from any liability in connection with any side effects or reaction related to the administration of the test.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### FOR EVANS URGENT CARE OFFICE USE ONLY:

CHEST X-RAY: (If applicable)	Date: ____/____/____	Results: _____
<b>TB/ PPD Test:</b>		
Site: _____ Administered by: _____ Admin. Date: _____		
Lot # _____		Exp. Date: _____

### 72 Hours Later:

Results: _____ mm	Results Recorded By:
<input type="checkbox"/> Negative <input type="checkbox"/> Presumptuous Positive Reaction	_____
Signature of Reader: _____ Date: ____/____/____	