



### Tuberculosis Screening Medical Questionnaire

Occupational Physician Paul Christensen, MD at Industrial Medical Group – 805- 922-8282

#### Section A-Employee Information

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ First Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Age: \_\_\_\_\_

Male  Female

Phone Number: \_\_\_\_\_ Best time to phone if necessary: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Your Job Title: \_\_\_\_\_

#### **Section B – Questions 1 through 8 below must be answered by every employee who will have a TB skin test.**

- 1. Have you had a TB skin test in the past? -----  Yes  No
- 2. If yes, were you told it was “positive” or was there any redness or swelling? -----  Yes  No
- 3. Have you ever had a BCG vaccine (given in countries outside of the U.S.?) -----  Yes  No
- 4. Have you or any of your family members been exposed to active TB? -----  Yes  No
- 5. Have you had a viral illness or received any vaccinations in the past four (4) weeks? -  Yes  No
- 6. Are you currently being treated for cancer? -----  Yes  No
- 7. Do you currently take any steroid medications? -----  Yes  No
- 8. Are you pregnant or nursing? \*-----  Yes  No

\*If you are pregnant or nursing, you will need permission from your physician prior to receiving this skin test.