Family Service
OF THE PIEDMONT

Name:	**D.O.B.**: _____
F.S.P.#:	
Medicaid #:	**IPRS / LME #**:

INITIAL TUBERCULOSIS SCREENING QUESTIONNAIRE

Date of Birth: _____ Today's Date: _____

1. Have you ever had a positive tuberculosis skin test?
   Yes ☐ No ☐ Don't Know ☐ If yes, when? _____

2. Has anyone you know or have lived with been diagnosed with tuberculosis in the past year?
   Yes ☐ No ☐ Don't Know ☐

3. Within the past 30 days, have you had any of the following symptoms, lasting more than 2 weeks?

Excessive sweating at night	Yes ☐	No ☐
Excessive weight loss	Yes ☐	No ☐
Coughing up blood	Yes ☐	No ☐
Excessive fatigue	Yes ☐	No ☐
Hoarseness	Yes ☐	No ☐
Persistent coughing	Yes ☐	No ☐
Persistent fever	Yes ☐	No ☐

4. Do you live with anyone that has had any of the above symptoms? Yes ☐ No ☐

_____ _____
Client Signature Date

_____ _____
Interviewer Signature Date