

## D. Early Detection of TB Questionnaire

### EARLY DETECTION OF TUBERCULOSIS QUESTIONNAIRE

This questionnaire will help identify patients who meet this facility's definition of "suspected infectious TB" so that appropriate precautions can be taken. An individual with two or more symptoms of TB, in addition to a prolonged cough, will be considered a suspected infectious TB patient unless the physician has ruled out this diagnosis.

HISTORY/SYMPTOMS	Yes	No	Don't Know
1. Do you have a cough that has lasted longer than 3 weeks?			
2. Have you lost your appetite?			
3. Have you lost weight without dieting?			
4. Have you had fever, chills, or night sweats?			
5. Have you coughed up blood?			
6. Have you been feeling very tired?			
7. Have you ever had a positive tuberculin skin test (TST) result or interferon gamma release assay (IGRA) result?			
8. Have you ever had an abnormal chest x-ray?			
9. Have you recently had the mucous you coughed up tested for TB?			
10. Have you ever been told you had TB?			
11. Have you ever taken medicine for TB?			
12. Have you ever lived with or had close contact with someone who had TB?			

#### EVALUATOR'S COMMENTS

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#### EXPOSURE CONTROL METHODS IMPLEMENTED

<input type="checkbox"/> Surgical mask on patient Date: _____ Time: _____	<input type="checkbox"/> Given tissues and instructions Date: _____ Time: _____
<input type="checkbox"/> Segregated in room Date: _____ Time: _____	<input type="checkbox"/> Placed in AIIR _____ Date: _____ Time: _____
<input type="checkbox"/> Sign placed on door Date: _____ Time: _____	<input type="checkbox"/> No action required Date: _____ Time: _____

Evaluator's signature \_\_\_\_\_ Date \_\_\_\_\_