

TUBERCULOSIS EVALUATION

DATE: _____

NAME: _____

REASON FOR EVALUATION: _____

HAS PATIENT EXPERIENCED ANY OF THE FOLLOWING:

	YES	NO
HISTORY OF EXPOSURE TO TB		
PREVIOUS TB INFECTION		
OLD COUGH (over 3 weeks)		
INCREASED COUGH		
PRODUCTIVE COUGH		
BLOOD IN SPUTUM		
TEMPERATURE (fever)		
LOSS OF APPETITE		
WEIGHT LOSS		
CHILLS		
NIGHT SWEATS		
CHEST PAIN		
FATIGUE		

RECOMMENDATION: _____

NURSE OR DOCTOR SIGNATURE: _____ DATE: _____