



**WARHAWK
HEALTH SERVICES**

TB Screening Questionnaire

Name: Lindy Long
Student Number: A02111371

Date of Birth: 10/07/99

Please mark "yes" or "no" to the following questions.

YES NO

1. Do you have a cough that has lasted longer than 3 weeks?		NO
2. Have you coughed up blood or mucus?		NO
3. Have you had fever, chills, or night sweats?		NO
4. Have you had unintentional weight loss?		NO
5. Have you been feeling very tired?		NO
6. Have you lost your appetite?		NO
7. Have you ever had a positive TB skin test result or Positive interferon gamma release assay (IGRA) result? If so, when?		NO
8. Have you ever had an abnormal chest x-ray?		NO
9. Have you recently had the mucus coughed up tested for TB?		NO
10. Have you ever been told you had TB or latent TB?		NO
11. Have you ever taken medicine for TB?		NO
12. Have you ever lived with or had close contact with someone who had TB?		NO
13. Do you currently have a rash on either forearm?		NO
14. Are you immunocompromised? (Steroids, chemotherapy, or other?)		NO
15. Have you received a live vaccine in the past 30 days?		NO

All TB skin test and Chest x-rays must be performed in the U.S. to be valid.

I attest the above is true and accurate to the best of my knowledge.

Patient Signature: Lindy Long

Date: 5/3/22

Provider Signature: [Signature] Date: 5/3/22

NO changes in consent per pt on 5/10/2024 01310
WBS JDRN