



**WARHAWK  
HEALTH SERVICES**

**TB Screening Questionnaire**

Name: SRI DIVYA PODILI

Date of Birth: March 28<sup>th</sup> 1998

Student Number: 500398829

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

YES NO

|                                                                                                                                             |  |   |
|---------------------------------------------------------------------------------------------------------------------------------------------|--|---|
| 1. Do you have a cough that has lasted longer than 3 weeks?                                                                                 |  | ✓ |
| 2. Have you coughed up blood or mucus?                                                                                                      |  | ✓ |
| 3. Have you had fever, chills, or night sweats?                                                                                             |  | ✓ |
| 4. Have you had unintentional weight loss?                                                                                                  |  | ✓ |
| 5. Have you been feeling very tired?                                                                                                        |  | ✓ |
| 6. Have you lost your appetite?                                                                                                             |  | ✓ |
| 7. <b>Have you ever had a positive TB skin test result or Positive interferon gamma release assay (IGRA) result?</b><br><b>If so, when?</b> |  | ✓ |
| 8. Have you ever had an abnormal chest x-ray?                                                                                               |  | ✓ |
| 9. Have you recently had the mucus coughed up tested for TB?                                                                                |  | ✓ |
| 10. Have you ever been told you had TB or latent TB?                                                                                        |  | ✓ |
| 11. Have you ever taken medicine for TB?                                                                                                    |  | ✓ |
| 12. Have you ever lived with or had close contact with someone who had TB?                                                                  |  | ✓ |
| 13. Do you currently have a rash on either forearm?                                                                                         |  | ✓ |
| 14. Are you immunocompromised? (Steroids, chemotherapy, or other?)                                                                          |  | ✓ |
| 15. Have you received a live vaccine in the past 30 days?                                                                                   |  | ✓ |

**\*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: P. Sridhar

Date: 10/05/21

Provider Signature: [Signature]

Date: 10/05/21