



**WARHAWK
HEALTH SERVICES**

TB Screening Questionnaire

Name: Coleene Rayborn

Date of Birth: Feb 8th 2006

Student Number: _____

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

YES NO

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

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.

Provider

Patient Signature: _____

Date: _____

Patient

Provider Signature: Coleene Rayborn

Date: 8/4/23

sorry !!

Coleene Rayborn RN 8/4/23