Tuberculosis Questionnaire

Elizabeth Salada, MD A Medical Corporation

Patient Name: _____ Date of Birth: _____

Today's Date: _____

1. Have you ever had tuberculosis (TB)? Yes No
2. Have you been living with anyone in the past 2 years who have been diagnosed with TB? Yes No
3. Have you had a productive cough for more than 3 weeks? Yes No
4. Have you had unexplained fever, chills or night sweats? Yes No
5. Have you been coughing up blood sputum (saliva)? Yes No
6. Have you had unexplained loss of appetite or weight loss? Yes No
7. Have you had contact with anyone diagnosed with active TB in the past year? Yes No