



Tuberculin (PPD) SCREENING
Questionnaire and Consent Form

Name: _____ Employer: _____

Date: _____ Test: Pre-Placement Annual Two-Step

1. Have you had any of the following symptoms during the past year for more than two weeks, NOT associated with a specific illness?
 - a. Unexplained and/or low grade fever. Yes No
 - b. Night sweats. Yes No
 - c. Unexplained weight loss of more than 5 lb. Yes No
 - d. Persistent cough. Yes No
 - e. Coughing up phlegm or blood. Yes No
 - f. Loss of appetite. Yes No
 - g. Unusual fatigue. Yes No

2. Are you taking any medications? Yes No
 Indicate which: _____
 Certain medicines can affect your immune system and change your response to the TB skin test. We may need to test you for this.

3. Were you ever vaccinated against tuberculosis? Yes No

4. Were you vaccinated in the past year? Yes No
 Indicate which: _____

5. Have you had an infection in the last month? Yes No

6. Have you ever had a positive TB skin test? Yes No

7. Have you ever been diagnosed or treated for TB? Yes No

If YES, which medication did you receive? _____

8. When was your last chest x-ray? _____

PATIENT INSTRUCTIONS

You have been given a tuberculin skin test that must be read within 48 to 72 hours. If not, it will be considered invalid and will have to be repeated. Please make arrangements with our staff so it can be read properly. Thank you.

PATIENT STATEMENT

I hereby certify that to the best of my knowledge, I have had neither a severe reaction to tuberculin (PPD) test nor have I had tuberculosis in the past. Therefore, I hereby authorize Affinity Immediate Care to administer to me a tuberculin (PPD) test as required by my prospective/current employer. I understand that if the test reaction is not read in 48 to 72 hours after its administration, it will have to be repeated.

Patient Signature: _____ Date: _____