TUBERCULOSIS RISK QUESTIONNAIRE

UNIVERSITY LA VERNE
STUDENT HEALTH CENTER

IMPORTANT: READ THIS BEFORE SIGNING BELOW

I have been given and have read, or have had explained to me, the information contained in the "Vaccine Information Statement(s)" about the diseases(s) and vaccine(s) indicated below. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated below be given to me or to the person named below for whom I am authorized to make this request.

DATE: _____ NAME _____ ID _____

ANSWER THE FOLLOWING QUESTIONS

1. Have you ever had a positive TB (Tuberculosis) skin test (PPD)?	Yes	No
2. Have you ever had a positive TB blood test (QuantiFERON GOLD)?	Yes	No
3. Have you ever had close contact with anyone who was sick with TB?**	Yes	No
4. Were you born in one of the countries listed below?	Yes	No
5. Have you ever had an extended stay, 1 months or more, in any of the following areas with a high prevalence of TB as defined by the World health Organization (see below)?**	Yes	No

- **Africa**- all countries
- **Asia/Southeast Asia/Pacific Islands**- all countries
- **North, Central & South America-** Argentina, Bahamas, Belize, Bolivia, Brazil, Costa Rica, Colombia, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Venezuela
- **Europe**- Belarus, Bosnia, Herzegovina, Bulgaria, Croatia, Estonia, Hungary, Latvia, Lithuania, Macedonia, Moldova, Poland, Portugal, Romania, Russian Federations, Serbia, Slovak Republic, Slovenia, Ukraine, Yugoslavia
- **Middle East**- Bahrain, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Syrian Arab Republic, Turkey, Yemen

SCREENING QUESTIONNAIRE FOR ADULT IMMUNIZATION		
1. Are you sick today?	Yes	No
2. Do you have allergies to medications, food, or any vaccine?	Yes	No
3. Have you ever had a serious reaction after receiving a vaccination?	Yes	No
4. Do you have cancer, leukemia, AIDS, or any other immune system problem?	Yes	No
5. Do you take cortisone, prednisone, other steroids, anticancer drugs, or radiation treatments (immunocompromised)?**	Yes	No
6. During the past year, have you received a transfusion of blood or plasma, or been given a medicine called immune (gamma) globin in the past year?	Yes	No
7. For women: Are you pregnant or is there a chance you could become pregnant in the next three months?	Yes	No
8. Have you ever had a reaction to a TB skin test	Yes	No
9. Have you had an unexplained weight loss in the last year	Yes	No
10. Do you have a persistent cough (lasting more than 3 weeks)?	Yes	No
11. Do you cough up blood?	Yes	No
12. Do you have persistent, unexplained fevers or night sweats?	Yes	No

**Specific questions for Healthcare Personnel

_____ _____

Healthcare Clinician Signature Date