

**CONTRA COSTA COUNTY HIV SERVICES
Tuberculosis Screening Client Questionnaire**

Part I	
Client Name:	
Client ID#:	
Today's Date:	
Date/Result/Provider of last skin test:	
Date/Result/Provider of last chest X-ray:	

Part II: TB Exposure Questionnaire	
1. Have you ever had TB disease before?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever taken any TB medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you have any sputum production when you cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you have blood or brown-tinged sputum?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you had any contact with a person with an active case of TB since your last TB test?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do you have any night sweats or chills?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you been in jail or prison in the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you been homeless or lived in a shelter in the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If the client answers "yes" to any of the above questions and has not had a TB test in the last six months, refer them to their primary care provider for TB screening.