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## TUBERCULOSIS QUESTIONNAIRE

Patient: \_\_\_\_\_

- |  | YES | NO  |
|--|-----|-----|
| 1. Have you ever been diagnosed with TUBERCULOSIS (TB)?  | ___ | ___ |
| 2. Have you ever been exposed to TB?<br>If yes, please explain _____   | ___ | ___ |
| 3. Have you ever had a BCG (vaccination for TB)?<br><b>ANSWER "NO" UNLESS YOU WERE BORN IN A FOREIGN COUNTRY</b> | ___ | ___ |

**HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS WITHIN THE PAST YEAR?**  
**If you answer YES to any of these questions, please explain in the comments section**

- |  | YES | NO  |
|--|-----|-----|
| 1. Unexplained weight loss?                              | ___ | ___ |
| 2. Persistent cough?                                     | ___ | ___ |
| 3. Chest pain?   | ___ | ___ |
| 4. Night Sweats?   | ___ | ___ |
| 5. Fever in late afternoon or evening?                   | ___ | ___ |
| 6. Productive cough with yellow, green or bloody sputum? | ___ | ___ |
| 7. Do you smoke? If yes, how many per day? _____         | ___ | ___ |

**COMMENTS:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Reviewed by PRE-OP RN

\_\_\_\_\_  
 (X) PATIENT SIGNATURE