



Gwinnett Newton and Rockdale County Board of Health Tuberculosis Testing Tracking Form: School Based Testing

M&M#: _____

Patient Information:

Last Name: _____ First Name: _____ Birth Date: _____
mm/dd/yyyy

Race: _____ Ethnicity (*circle one*): Hispanic Non-Hispanic Sex (*circle one*): Male Female Other

1. Have you ever had a positive / reactive (+) TB skin test or blood test? Yes No Unsure
If yes, did you take medicine? Yes No Unsure
What medicines: _____ How long: _____ Dates: _____
2. Have you had any vaccines in the past 30 days (*Oral Polio, MMR, Rotavirus, Yellow Fever*)? Yes No Unsure
If yes, what vaccine(s) and when? _____
3. Has anyone you know had TB or been treated for TB? Yes No Unsure

Do you have any medical conditions that may affect your immune system? Yes No Unsure
 Diabetes Kidney Disease Cancer Oral / Injectable Steroid Use Pregnant
 Other: _____

Have you had any of the following symptoms? *Check all that apply.*
 Cough that wont go away Fever Night Sweats Weight Loss Loss of Appetite
 Coughing up blood Chills Loss of Energy Chest pain None

TST Information Arm (*circle one*): Right Left

Date Placed: _____ PPD Lot # _____ Exp: _____ Placed by: _____
Date Read: _____ Results (*in mm*): _____ Read by: _____

Screening Questions:

1. Have you lived, traveled, or had visitors from outside the US? Yes No Unsure
If yes, please give details: _____
2. Are you involved in any extracurricular activities, clubs, sports, church, etc? Yes No
If yes, please give details: _____
3. How do you get to school?
 Bus Number and Seat: _____ Car Occupants _____
4. Are you dual enrolled or go to other schools than Discovery? Yes No
If Yes, where: _____
5. What is your lunch period?: _____ 6. Where do you work?: _____
7. Where do you spend your free time? What do you do on the weekends?

8. Do you drink alcohol? Yes No
If yes, when was your last drink?: _____
Do you drink alone or with other people?: _____
9. Do you inject drugs: Yes No
If yes, are you alone or with other people?: _____
10. Do you smoke marijuana, tobacco, hookah, e-cigarettes, or other drugs? Yes No
If yes, do you use a bong, or similar shared device with others? Yes No
If you smoke joints / (e-)cigarettes or similar, are you usually with others? Yes No
11. Have you ever spent time in a correctional facility, treatment center, homeless shelter, or similar location that housed a large number of people (this includes volunteering / visiting also)? Yes No Unsure

Notes:

Provider Office Information

Clinic Name: _____
Provider Name: _____
Phone: _____ Fax: _____