GNR PUBLIC HEALTH

PREVENTIVE HEALTH CLINIC
455 Grayson Highway, Suite 400
Lawrenceville, GA 30046
678.442.6880
866.399.7601
www.gnrhealth.com

PLACE PATIENT LABEL HERE

QFT AND TST SCREENING

Please read this form carefully. If you have any questions, ask the provider before they perform the test.

Reason for Screening

☐ Medical condition / Physician referral ☐ School / Work ☐ Immigration ☐ Other:_____

Patient Information

1. I understand that testing indicates if I have been exposed to the bacteria that causes Tuberculosis:
   ☐ No ☐ Yes
2. Country of birth: _____
3. History of BCG vaccine: ☐ No ☐ Yes
4. History of positive QFT or TST: ☐ No ☐ Yes Result in mm: _____ Date of test: _____
5. Chest x-ray results: ☐ Normal ☐ Abnormal Date and location of x-ray:_____
6. Prior treatment for TB / LTBI: ☐ No ☐ Yes If yes, list the medication you took, how long you took it, and who prescribed you the medication: _____
7. Have you received an mRNA COVID-19 or live (Adenovirus, BCG, Chikungunya, Cholera, Dengue, Ebola, FluMist, MMR, oral Polio, Rotavirus, Smallpox/Mpox, Varicella, Vivotif, Yellow Fever, or Zostavax) vaccine within the past 30 days?: ☐ No ☐ Yes
8. Do you have any medical conditions (e.g., pregnancy, cancer, diabetes, HIV, lupus, psoriasis, rheumatoid arthritis, etc.)?: ☐ No ☐ Yes If yes, list: _____
   _____
9. Current medications:_____
10. History of incarceration: ☐ No ☐ Yes Facility and location: _____
11. Employment status: ☐ Unemployed ☐ Employed Employer and location: _____

TB Symptom Screening

☐ Coughing longer than 2 weeks	☐ Shortness of Breath	☐ Night sweats
☐ Coughing up blood / sputum	☐ Loss of energy / Weakness	☐ Loss of appetite
☐ Chest Pain	☐ Fever / Chills	☐ Unexplained weight loss

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____