

TUBERCULOSIS PROVIDER REVIEW

NAME _____ DATE _____

BIRTH DATE _____ SOCIAL SECURITY NUMBER _____

Positive TB Skin Test (PPD) Date: _____
Induration: _____ mm

Last Chest X-Ray Date: _____
Results: _____

INH Therapy YES or NO
Date Started: _____ End Date: _____

BP _____ TEMP _____

P _____ RESP _____

HT _____ WT _____

MEDS _____

ALLERGIES _____

Please indicate if you have had any of the following problems for 3 to 4 weeks or longer.

- 1. Chronic Cough (greater than 3 weeks) YES _____ NO _____
- 2. Production of Sputum YES _____ NO _____
- 3. Unexplained Weight Loss YES _____ NO _____
- 4. Fever YES _____ NO _____
- 5. Fatigue / Tiredness YES _____ NO _____
- 6. Night Sweats YES _____ NO _____

EXAMINATION

- 1 General
- 2 Skin
- 3 Lymph Nodes
- 4 Neck/thyroid
- 5 Respiratory
- 6 Abdomen
- 7 Cardio

	Normal	Abnormal	No exam
1 General			
2 Skin			
3 Lymph Nodes			
4 Neck/thyroid			
5 Respiratory			
6 Abdomen			
7 Cardio			

HPI/ROS: _____

OBJECTIVE: _____

ASSESSMENT: _____

PLAN: CXR Required YES _____ NO _____ Results _____
 Evidence of active disease YES _____ NO _____
 Return to Clinic 1 year YES _____ NO _____

Provider Signature _____

Provider Address: _____ Phone No. _____