Name _____ DOB: _____

Please Print

Address: _____ Telephone: _____

Physician Name and Location: _____

1. Have you ever lived or traveled to another country? Yes No
   a. If yes, when and where: _____
2. Have you ever had a positive PPD skin test? Yes No
   a. If yes, date _____ and size in _____ mm induration.
   If yes , Date of your last Chest X-ray _____
3. Have you ever been told you have active or latent tuberculosis? Yes No
   a. If yes, name of medication (s} _____ and duration the medications were taken _____ months.
4. Has a close member of your family ever been diagnosed or treated for tuberculosis? Yes No
5. During the past year have you had any symptoms below?
   - Unexplained weight loss? Yes No
   - Decrease in appetite? Yes No
   - Persistent cough? Yes No
   - Blood streaked sputum? Yes No
   - Night Sweats? Yes No
   - Unexplained low grade fever? Yes No
   - Swelling of the lymph nodes? Yes No
   - Unusual tiredness or fatigue? Yes No

Signature: _____ Date: _____

Reviewed By: _____ Date: _____

Step 1 PPD	Date Placed:		Date Read:		Manufacturer:
	Time Placed:		Time Read:		Lot #:
	R FA LFA		**mm induration:**		Exp. Date:
	Placed By:		Read By:		
	Comments:				
	Signature of Provider				Date:

Step 2 PPD	Date Placed:		Date Read:		Manufacturer:
	Time Placed:		Time Read:		Lot #
	R FA LFA		**mm induration:**		Exp. Date:
	Placed By		Read By		
	Comments:				
	Signature of Provider				Date:

Consent for Mantoux testing :

Patient/Parent/ Legal Guardian Signature:_____Date_____

Patient Test ID # _____

Jo Daviess County Health Department

9483 US RT 20 West

Galena Illinois 61036

815-777-0263