



# Iowa Department of Public Health

## Tuberculosis Control Program

### TB Screening Form

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

<b>Signs and Symptoms of TB Disease</b> Persons who answer "yes" to any of the following signs and symptoms warrant further investigation to rule out active infectious pulmonary/laryngeal TB.	<b>Yes</b>	<b>No</b>
1. Productive cough of more than three (3) weeks duration	<input type="checkbox"/>	<input type="checkbox"/>
2. Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>
3. Persistent fevers	<input type="checkbox"/>	<input type="checkbox"/>
4. Drenching night sweats	<input type="checkbox"/>	<input type="checkbox"/>
5. Unplanned weight loss	<input type="checkbox"/>	<input type="checkbox"/>

This assessment was completed by (print name): \_\_\_\_\_

Signature: \_\_\_\_\_

Date of assessment: \_\_\_\_\_

If referral is needed list the name of provider/clinic to which the person was referred:

\_\_\_\_\_