ADARA
HEALTHCARE STAFFING

Date Form Completed: _____

First Name: _____ Last Name: _____

Date of Birth: _____ SSN: _____

Medical History and Risk Factor Review:

Most recent TB skin test: YEAR_____ Reading (mm): _____

Read Positive or Negative _____

Since your last TB skin test have you entered a TB isolation room, lived with or had close contact to someone who has TB disease? _____YES _____NO _____ Don't Know

If YES, please specify location _____Time at location _____

Since your last TB skin test have you traveled or lived overseas? _____YES _____NO

If yes, where? _____

Since your last TB test have you worked in a prison or homeless shelter? _____YES _____NO

Since your last TB skin test have you had an abnormal CXR? _____YES _____NO

If yes, when and what were the results? _____

Since your last TB skin test have you experienced any of the following symptoms for more than 3 weeks at a time?

Excessive sweating at night	YES NO	Hoarseness	YES NO
Excessive weight loss	YES NO	Persistent Coughing	YES NO
Coughing up blood	YES NO	Persistent Fever	YES NO

DATE TST Applied	Initials	Site RA/LA	Product Name	Lot #	Exp. Date	Date Read	Induration (mm)	Initials
/ /					/ /	/ /		
/ /					/ /	/ /		

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