INNOVATIONS

TUBERCULIN SKIN TEST QUESTIONNAIRE

Name:_____ Date:_____

Address:_____ Division:_____

_____

1. Do you have any allergies? ***YES*** No
   If yes, please list and explain type of reaction.

2. Have you ever received a TB skin test? Yes ***NO***
   If **yes**, did you develop a reaction to the test? ***YES*** No

3. Is there a possibility that you are pregnant? ***YES*** No
   If yes, c**ontact your physician prior to receiving the test.**

4. Have you been exposed to anyone with tuberculosis? ***YES*** No

5. Are you currently taking any medications? ***YES*** No

6. Have you ever received the BCG Vaccine (TB Vaccine in Europe)? ***YES*** No
   If yes, the TB test is contraindicated.

7. Have you had a viral disease or an inoculation for measles, chicken pox, rubella, mumps, polio or influenza in the last month? ***YES*** No
   If yes, testing needs to be delayed for one month after the viral disease or inoculation.

8. Have you received a TB test in the last 12 months? ***YES*** NO

I have read, discussed and received a copy of the sheet called "Information about Tuberculin Skin Testing", and I wish to be given the TB skin test.

Signature: _____ Date: _____

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Drug: Tubersol Site: Forearm L or R Route: Intradermal

Lot No.: _____ Exp. Date: _____ Dose: 0.1ml

Nurse: _____ Date Given: _____

Date Read:_____ Reading (mm):_____ Read by: _____