Saint Mary's College
Women's Health
TB (Tuberculin) Exposure Risk Assessment

Name: _____ Graduation year: _____ Phone: _____

Date of Birth: _____ Country of Birth: _____

If foreign born, year arrived in the USA: _____ BCG Vaccine: ___ No ___Yes When? _____

TB Test History

Date Given: _____ Result: _____ mm Facility: _____

SYMPTOMS

Please indicate any symptoms which have developed recently

	Yes	No		Yes	No
Fever	___	___	Chest Pain	___	___
Fatigue (tired)	___	___	Cough	___	___
Weight Loss	___	___	Bloody Sputum (spit)	___	___
Night Sweats	___	___	Loss of Appetite	___	___

Date Given: _____ Time: _____ Site: _____ Nurse: _____

Lot Number: _____ Expiration Date: _____

5 or more millimeters

__ Known TB Contact
__ HIV / AIDS
__ Organ Transplant
__ Immunosuppressed
__ Cancer / Hodgkins

10 or more millimeters

__ Resident Congregate Setting
__ Employee Congregate Setting
__ Foreign Travel (where?) _____
__ Healthcare Worker
__ Substance Abuse
__ Diabetic
__ Kidney Disease
__ Lung Disease
__ Prolonged Steroid Use
__ Gastrectomy

15 or more millimeters

__ No known Risk Factors

Date Read: _____ Time: _____ Reaction(mm): _____Nurse: _____

7/10