miOttawa Department of Public Health

Date_____

TB Health History

Name (Last, First, MI)			
DOB		**Sex:** ☐ **Male** ☐ **Female**	
Street	**City**	**State**	**ZIP**
County of residence	**Country of birth**	**In US since (year)**	
Phone	**Language(s) Spoken**	**Need Interpreter:** ☐ **Yes** ☐**No**	
Guardian/Contact	**Guardian/Contact Phone**	**Refugee:** ☐ **Yes** ☐ **No**	
Reason tested	**Person Completing Form**	**Referring Agency/Office**	
Any Known Exposure to TB Disease? ☐ **Yes** ☐ **No**		**History of BCG vaccine?** ☐ **Yes** ☐ **No**	
Have you ever taken medication for TB? ☐ **Yes** ☐ **No**			
Current Skin Test **Date Given**_____ **Date Read**_____ **Reaction Size**_____ **(mm)**		**IGRA (TB blood test)** **Date Drawn**_____ **Result**_____	
Chest X-ray Done? ☐**Yes** ☐**No**	**Location:**	**Date:**	**Result:**

☐ **No Symptoms**	☐ Cough	☐ Expectoration	☐ Night Sweats	**Weight**
	☐ Weight Loss	☐ Swollen glands	☐ Chest Pain	
☐ **Symptoms of TB**	☐ Fatigue	☐ Poor appetite	☐ SOB	**Height**
please check ➔	☐ Fever	☐ Blood in sputum		

☐ **NO SIGNIFICANT MEDICAL HISTORY REPORTED**

☐ **MEDICAL HISTORY**	☐ Cortisone Therapy	☐ IV Drug Use
☐ Diabetes	☐ Immunosuppressed	☐ Previous Liver Disease
☐ Hepatitis	☐ On Birth Control	☐ Prior Abnormal LFT
☐ Leukemia	☐ Pregnant Due Date_____	☐ Current use of medication requiring LFT
☐ Lung Disease	☐ Alcohol Use	
☐ Smoker		

Other Health History:_____

Medications:_____

_____

_____

Allergies? ☐ **Yes** ☐ **No** _____

Primary Care Physician	
Phone:	**Fax:**

Communicable Disease Unit Phone: 616-396-5266 Fax: 616-393-5767