ameristar home care

Applicant/Employee Name: _____ Date: _____

FINAL MEDICAL REPORT

TB Screening Questionnaire	
1. TBS – Have you ever had a test for TB?	
2. TBS – If you have had a TB test, please specify the PPD test date.	
3. TBS – If you have had a TB test, please specify the PPD test result and mm of induration, if know.	
4. TBS – if you have had a TB test, please specify the Chest x-ray date.	
5. TBS – if you have had a TB test, please specify the Chest x-ray result.	
6. TBS – Do you have any of the following symptoms?	
7. TBS – What color is your sputum (if present)?	
8. TBS – Have you ever been exposed to anyone exhibiting the above signs or symptoms, or someone who has had active TB?	
9. TBS – If you have been exposed and received treatment, what type of treatment did you receive?	
10. TBS – If you have received treatment, for how long?	
11. TBS – Have you ever had cancer of the head, neck or lung; or had leukemia or lymphoma?	
12. TBS – Have you ever had an organ or tissue transplant?	
13. TBS – Are you taking steroids, chemotherapy, or drugs that affect your immune system?	
14. TBS – Do you have diabetes or high blood sugar?	
15. TBS – Do you have renal failure or are you on kidney dialysis?	
16. TBS – Do you think you are at risk of having HIV infection?	
17. TBS – Have you ever injected street drugs?	
18. TBS – Were you born outside of the United States	
19. TBS – If you were born outside of the United States, where?	
20. TBS – Have you ever traveled to any other countries recently for more than one (1) month?	
21. TBS – If you have traveled recently, to where?	
22. TBS – Have you ever lived or worked in a group setting such as a hospital, nursing home, drug treatment center, homeless shelter, jail or prison?	

Physician Signature: _____

Physician Name: _____

Physician Address: _____

Physician License #: _____

Date: _____

MD Office, please fax this completed form to 718-337-1101. Thank you.