CLARKSBURG MEDICAL CENTER

TB SKIN TEST (PPD) QUESTIONAIRE

You will be given a skin test for Tuberculosis. Please circle one answer.

1. Have you had a TB skin test in the past? YES NO
2. If yes, were you told it was 'positive' or was there any redness or swelling? YES NO
3. Have you ever had a BCG vaccine (given in countries outside of the U.S)? YES NO
4. Have you or any of your family members been exposed to active TB? YES NO
5. Have you had a viral illness or received any vaccinations in the past 4 weeks? YES NO
6. Do you currently take cancer medicine or steroids? YES NO
7. Are you pregnant or nursing? YES NO

IF YOU ARE PREGNANT OR NURSING, YOU WILL NEED PERMISSION FROM YOUR PHYSICIAN PRIOR TO TAKING THIS TEST.

Print name: _____

Date: _____

SS#: _____ Date Of Birth: _____

FOR OFFICE USE ONLY:

TEST GIVEN: _____ DATE: _____

MFG & LOT#: _____ EXPIRATION DATE: _____

ARM: RIGHT LEFT PRACTITIONER: _____

RESULTS: _____ DATE: _____

PRACTITIONER: _____

Notes: