Outcomes

TUBERCULIN SKIN TESTING (TST) ONE-STEP

PATIENT INFORMATION *(Please print clearly)*

Last Name: **First Name:**	**D.O.B.:** **Age:** **Gender:** **Height:** **Weight:**
Home Address:	Contact Phone:
City:	State: Zip:
Primary Care Physician:	Physician Phone:
Physician Address:	Physician Fax #:
Please state any past medical history and chronic conditions:	
Current medications:	
Allergies (please state reaction that occurs when exposed to the allergen):	
Vaccination History:	

SCREENING QUESTIONNAIRE

	Yes	**No**	**Don't Know**
Do you require TST documentation for school or insurance purposes?	☐	☐	☐
Do you have an allergy to TST, or history of allergic reaction to TST? If yes, what was the reaction?	☐	☐	☐
Have you ever had a severe reaction such as necrosis, blistering, anaphylactic shock, or ulcerations after a previous TST?	☐	☐	☐
Do you have documented active TB or history of treatment for TB infection?	☐	☐	☐
Do you have a history of positive TST?	☐	☐	☐
Do you have any burns or eczema on your forearms?	☐	☐	☐
Have you had any vaccinations in the last 28 days? *If yes, please list:*	☐	☐	☐
Have you had a bacilli Calmette-Guerin (BCG) vaccination in the past?	☐	☐	☐
Will you require annual TB testing?	☐	☐	☐
Are you able to return to this location in 48-72 hours for interpretation of the TST?	☐	☐	☐
Do you currently smoke tobacco? *If yes, how many packs per day?*	☐	☐	☐
Do you currently consume alcohol? *If yes, how many drinks per week?*	☐	☐	☐
Do you currently use any recreational drugs? *If yes, please indicate which drugs and how often:*	☐	☐	☐