CHILDREN FIRST PEDIATRICS

ROCKVILLE, MD ***SILVER SPRING, MD***

TB PREVENTTIVE SCREEN QUESTIONAIRRE

(STARTING AT 6 MONTHS….DONE YEARLY) Please fill in Yes or No to each question

Patient Name:_____

DOB:_____Date completed:_____

1. Has your child been exposed to anyone with a case of TB? YES ☐ NO ☐

2. Was your child, or a household member, born in an area where TB is common? YES ☐ NO ☐

3. Has your child or household member lived more than a year in an area where TB is common? YES ☐ NO ☐

4. Does your child have daily contact with adults at high risk for TB? (HIV infected, homeless, incarcerated, and/or illicit drug users?) YES ☐ NO ☐

5. Does your child have HIV infection? YES ☐ NO ☐