



**ASHLAND COUNTY - CITY HEALTH DEPARTMENT**

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*Jelayne Dray RN, MSN, Health Commissioner*  
*Equal Opportunity Employer / Provider*

**TUBERCULOSIS SCREENING**

Please answer the following questions to determine your risk of tuberculosis infection and the need for TB skin testing.

NAME: \_\_\_\_\_

D.O.B. \_\_\_\_\_

YES            NO

Have you had close or prolonged contact with someone sick with tuberculosis or someone with a positive TB skin test? \_\_\_\_\_

Were you born in or did you live in Africa, Asia, Eastern Europe, South/Central America, or any countries of the former Soviet Union? \_\_\_\_\_

Have you traveled to any of the above countries within past 5 years? \_\_\_\_\_

Have you ever had a chest x-ray suggestive of inactive or past TB? \_\_\_\_\_

Have you been a resident or employee of a high-risk congregate setting? (such as correctional facility, nursing home, hospital, homeless shelter) \_\_\_\_\_

Are you taking any medication that your doctor said could suppress your immune system or make you prone to infection? \_\_\_\_\_

Have you ever used drugs not prescribed by a doctor? (such as marijuana, heroin, cocaine, including alcohol abuse) \_\_\_\_\_

Do you have any of the following medical conditions: *(please circle)*  
 diabetes mellitus, silicosis, cancer of head or neck, end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, organ transplant recipient, HIV infection, Hodgkin's disease, leukemia \_\_\_\_\_

Are you a health care worker who serves high-risk clients (see above)? \_\_\_\_\_

For children: has this child had *prolonged* exposure to anyone homeless, incarcerated, resident of a nursing home, user of illicit drugs, HIV patient, migrant farm worker? \_\_\_\_\_

Do you have any of these symptoms: bad cough for over 2 weeks, persistent fever, coughing up blood, excessive weight loss, fatigue, night sweats? \_\_\_\_\_

**Please return this form to your employer or school.**

Signature of patient/parent/guardian \_\_\_\_\_ Date \_\_\_\_\_