

Monument Avenue Pediatrics Tuberculosis Risk Assessment

Patient Name: _____

Date: _____

DOB: _____

1. Was your child born outside the United States? Yes No

If yes, Where? _____

2. Has your child ever traveled outside the United States? Yes No

If yes, Where _____

When? _____

How long? _____

3. Has your child been exposed to anyone with TB disease? Yes No

4. Does your child spend time with anyone who has been in jail (or prison) or a shelter, uses illegal drugs, has HIV or lives in a nursing home? Yes No

5. Does your child have close contact with a person who has a positive TB skin test? Yes No

6. Has your child ever consumed raw milk or eaten unpasteurized cheese? Yes No

7. Was a household member (ie. parent, sibling) born outside the United States? Yes No

8. Has a household member ever traveled outside the United States? Yes No