Texas Department of State Health Services

Tuberculosis Initial Health Risk Assessment / History

SSN	Medicaid#	DOB	Sex	Phone 1
Last	**First**	**Middle**		**Phone 2**
Street Address	**City**	**County**	**State**	**Zip**

ATS Classification

☐ 0-No M. TB exposure, not infected	☐ 3-M. TB disease, clinically active
☐ 1-M. TB exposure, no evidence of infection	☐ 4-Previous M. TB disease, not clinically active
☐ 2-M. TB infection, no TB disease	☐ 5-M. TB suspect, diagnosis pending

Initial Assessment

Primary reason evaluated for TB: ☐ Contact investigation ☐ Immigration medical exam ☐ Health care worker ☐ Employment/administrative testing ☐ Targeted testing ☐ TB symptoms ☐ Abnormal chest radiograph (consistent with TB) ☐ Incidental lab result ☐ Unknown

Date of assessment:	Assessment conducted by:

Location of the assessment: ☐ Clinic ☐ Patient home ☐ Hospital ☐ Jail/prison ☐ Long term care facility ☐ Other, specify other:

Pediatric TB Patients (<15 years old)

Country of birth for primary guardian(s):	Primary guardian relationship:
Patient lived outside US for >2 months: ☐ Yes ☐ No ☐ Unknown	Countries:

Demographics

Country of birth:	Born in the US (or born abroad to a parent who was a U.S. citizen): ☐ Yes ☐ No

Date of arrival in the US:

Races: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Unknown ☐ Refuse	Ethnicity: ☐ Hispanic ☐ Not Hispanic or Not Latino ☐ Unknown ☐ Refused
	Middle Eastern: ☐ Yes ☐ No
Extended race(s):	If yes, specify country(ies):

Foreign Birth or Travel

Immigration status at first entry to the US: ☐ Not applicable ☐ Immigrant visa ☐ Student visa ☐ Employment visa ☐ Tourist visa ☐ Family/fiancé visa ☐ Refugee ☐ Asylee or parolee ☐ Other immigration status ☐ Unknown
Specify other:

Notice of arrival of alien with TB class: ☐ A ☐ B1 ☐ B2 ☐ B3	Alien number:

Binational status: ☐ Contacts ☐ Laboratory/radiologic testing ☐ Counter Border Crosser or Transnational ☐ Not Counted Border Crosser ☐ Counted by Binational Program Only/Binacional

Residence or travel in country with high prevalence of TB in last 2 years: ☐ Yes ☐ No	Country:
Date of travel:	Approximate length of stay/residence:
Have you traveled for 8 consecutive hours while symptomatic? ☐ Yes ☐ No	Method of transportation: ☐ Flight ☐ Bus ☐ Train ☐ Ship/boat Specify:

Comments:

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Previous History of TB and TB Infection

Recurrence or previous diagnosis of TB or TB infection: ☐ TB Disease ☐ TB Infection ☐ No ☐ Unknown	
History: ☐ Documented ☐ Self report	Previous TB occurred in US: ☐ Yes ☐ No
State/Country:	State case number (if reported in Texas after 1993):
Most recent year of previous diagnosis:	More than one previous episode: ☐ Yes ☐ No ☐ Unk
Start date previous TB treatment: Stop date previous TB treatment: Previous TB drug regimen/Dosage (mg): Previous TB treatment documented: ☐ Yes ☐ No ☐ Unknown Previous TB treatment considered complete: ☐ Yes ☐ No ☐ Unknown	Start date previous TB infection treatment: Stop date previous TB infection treatment: Previous TB infection drug regimen/Dosage (mg): Previous TB infection treatment documented: ☐ Yes ☐ No ☐ Unknown Previous TB infection treatment considered complete: ☐ Yes ☐ No ☐ Unknown
Previous positive IGRA: ☐ Yes ☐ No ☐ QFT ☐ T-SPOT Date:	Date of chest X-Ray: Result: ☐ Abnormal ☐ Normal ☐ Unknown
Previous positive TST: ☐ Yes ☐ No Induration: mm Date:	Abnormal result: ☐ Cavitary ☐ Non-cavitary
Comments:	

History of TB Exposure

Known exposure to active TB case: ☐ Yes ☐ No	How many years: ☐ Greater than 3 years ☐ 3 years or less
Date:	Relationship to patient:
Comments:	

Symptoms

TB symptoms screening performed: ☐ Yes ☐ No	Patient is symptomatic: ☐ Yes ☐ No ☐ Unknown
Date of TB symptoms assessment:	

Symptom	***Onset date***	***Symptom***	***Onset date***
Chest pain: ☐ Yes ☐ No ☐ Not applicable		Weight loss (>10%): ☐ Yes ☐ No ☐ Not applicable	
Shortness of breath: ☐ Yes ☐ No ☐Not applicable		Frequent urination, bloody urine or flank pain: ☐ Yes ☐ No ☐ Not applicable	
Fever/chills: ☐ Yes ☐ No ☐ Not applicable		Headache, decreased level of consciousness or neck stiffness: ☐ Yes ☐ No ☐ Not applicable	
Night sweats: ☐ Yes ☐ No ☐ Not applicable		Swelling of joint/vertebra: ☐ Yes ☐ No ☐ Not applicable	
Cough (persistent x3 weeks): ☐ Yes ☐ No ☐ Not applicable		Enlarged cervical lymph nodes: ☐ Yes ☐ No ☐ Not applicable	
Productive cough: ☐ Yes ☐ No ☐ Not applicable		Swelling of lymph nodes: ☐ Yes ☐ No ☐ Not applicable	
Hemoptysis: ☐ Yes ☐ No ☐ Not applicable		Eye pain or blurry vision: ☐ Yes ☐ No ☐ Not applicable	
Fatigue: ☐ Yes ☐ No ☐ Not applicable		Pain swelling in other locations: ☐ Yes ☐ No ☐ Not applicable	
Loss of appetite: ☐ Yes ☐ No ☐ Not applicable		Other: ☐ Yes ☐ No ☐ Not applicable Specify other:	

Source of symptom information: ☐ Patient interview ☐ Relative/friend ☐ Medical record ☐ Other Specify other:	Respiratory isolation indicated: ☐ Yes ☐ No Date placed in respiratory isolation:
Notes:	

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Clinical		
Date of clinical assessment:		
Weight: lbs kgs Height: ft in cm	Recommendations based on BMI:	
Weight at least 10% less than ideal body weight: ☐ Yes ☐ No	Comments:	
Estimated weight, 3 months ago: lbs kg		
Blood pressure: systolic diastolic		
Date temperature collected:	Temperature: F C	

Medical History	
Date medical history collected:	
Allergies: ☐ Yes ☐ No	Comments:
Arthritis/gout: ☐ Yes ☐ No Use of ☐ Remicade ☐ Humira ☐ Enbrel	Comments:
Autoimmune: ☐ Yes ☐ No	Comments:
Cancer: ☐ Head ☐ Neck ☐ Other Specify other:	Comments:
Chronic malabsorption syndrome: ☐ Yes ☐ No	Comments:
Chronic renal failure: ☐ Yes ☐ No	Comments:
Corticosteroids (received equivalent of >15 mg/d Prednisone for >1 month): ☐ Yes ☐ No	Comments:
Diabetes mellitus: ☐ Yes ☐ No ☐ Type 1 ☐ Type 2	Comments:
Diabetes controlled: ☐ Yes ☐ No ☐ Unknown	Comments:
Controlled through: ☐ Pills ☐ Insulin ☐ Unknown	Comments:
GI/gastrectomy or jejunoileal bypass: ☐ Yes ☐ No	Comments:
Gynecological: ☐ Yes ☐ No	Comments:
Heart disease/PVD: ☐ Yes ☐ No	Comments:
Hypertension/CVA: ☐ Yes ☐ No	Comments:
Intellectual disability/developmental delay: ☐ Yes ☐ No	Comments:
Leukemia: ☐ Yes ☐ No	Comments:
Liver disease/hepatitis (risk factors HepB/C: IDU, HIV+ or birth in Asia, Africa or Amazon basin): ☐ Yes ☐ No	Comments:
Lymphoma: ☐ Yes ☐ No	Comments:
Mental illness(es): ☐ Yes ☐ No ☐ Anxiety ☐ Depression ☐ Schizophrenia ☐ Other ☐ Unknown Specify other: When (select all that apply): ☐ Currently ☐ Within past 12 months ☐ Ever	Comments:
Neurological/seizures: ☐ Yes ☐ No	Comments:
Organ transplant: ☐ Yes ☐ No	Comments:
Post partum: ☐ Yes ☐ No	Comments:
Respiratory problems: ☐ Yes ☐ No	Comments:
Silicosis/asbestosis: ☐ Yes ☐ No	Comments:
Skin disease: ☐ Yes ☐ No	Comments:
STD: ☐ Yes ☐ No	Comments:
Surgeries/hospitalizations: ☐ Yes ☐ No	Comments:
Thyroid: ☐ Yes ☐ No	Comments:
Vision/hearing disorder: ☐ Yes ☐ No	Comments:
Other medical history: ☐ Yes ☐ No Specify other:	Comments:

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Primary care provider: ☐ Yes ☐ No	Name of primary care provider:	Phone:
Specialty care provider: ☐ Yes ☐ No		
Specialty type: ☐ Pulmonologist ☐ Infectious disease ☐ Internal medicine ☐ Neurologist ☐ Other Specify other:	Name of specialty care provider: Phone:	
HIV status: ☐ Indeterminate ☐ Negative within past year ☐ Not offered ☐ Positive ☐ Refused ☐ Test done-results unknown ☐ Unknown	City/County HIV#:	
CD4 count, if HIV+:	Date, if HIV+:	
HIV counseling and referral provided: ☐ Yes ☐ No		

Medications taking (excluding TB drugs)

Medication	Start date	Dosage/schedule	Stop date	Prescribing Provider/Facility

(Attach additional medication list, if needed)

Name of person taking history:	
Name of interpreter (if used):	
Barriers to compliance: ☐ Yes ☐ No	Comments:
Live virus immunization in last 6 weeks: ☐ Yes ☐ No Date:	
Immunizations received: ☐ FluMist (influenza) ☐ MMR (measles, mumps, rubella) ☐ MMRV (measles, mumps, rubella, varicella) ☐ Rotavirus ☐ Herpes zoster (shingles) ☐ Smallpox ☐ Varicella ☐ Yellow fever	

Pregnant / Pregnancy

Patient is pregnant: ☐ Yes ☐ No ☐ Unknown	If no, Patient pregnant within year previous to diagnosis: ☐ Yes ☐ No ☐ Unknown
If yes, as of (date):	Outcomes(s): ☐ Live birth ☐ Miscarriage ☐ Still birth ☐ Termination ☐ Other Specify other:
Due date:	Outcome date:
Placenta evaluated: ☐ Yes ☐ No	Term delivery: ☐ Yes ☐ No ☐ Unknown
Pregnancy clinical notes:	Baby evaluated for TB: ☐ Yes ☐ No ☐ Unknown Evaluation result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Other ☐ Unknown Specify other: Outcome of evaluation: ☐ TB infection ☐ TB infection window period ☐ TB suspect ☐ TB disease ☐ No TB disease or infection
	Live birth facility:
	Did anyone in the patient's household have a baby in the last 3 months? ☐ Yes ☐ No ☐ Unknown

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Risk and Social History

Population Risks	Medical Risks
Contact to infectious TB patient (2 years or less): ☐ Yes ☐ No ☐ Unknown	Cancer: ☐ Head ☐ Lung ☐ Neck
Contact to MDR-TB case (2 years or less): ☐ Yes ☐ No ☐ Unknown	Chronic renal failure or on hemodialysis: ☐ Yes ☐ No ☐ Unknown
Inner-city resident: ☐ Yes ☐ No ☐ Unknown	If patient has diabetes, was nutrition education provided: ☐ Yes ☐ No
Low income: ☐ Yes ☐ No ☐ Unknown	End-stage renal disease: ☐ Yes ☐ No ☐ Unknown
History of homelessness (current or previous): ☐ Yes ☐ No ☐ Unknown	History of untreated or inadequately treated active TB, including fibrotic changes on X-Ray consistent with previous TB: ☐ Yes ☐ No ☐ Unknown
Current resident of homeless shelter: ☐ Yes ☐ No ☐ Unknown	Immunosuppression (not HIV/AIDS): ☐ Yes ☐ No ☐ Unknown
Homeless within past year: ☐ Yes ☐ No ☐ Unknown	Incomplete TB infection therapy: ☐ Yes ☐ No ☐ Unknown
History of incarceration (current or previous): ☐ Yes ☐ No ☐ Unknown	Missed contact (2 years or less): ☐ Yes ☐ No ☐ Unknown
Type of correctional facility: ☐ Federal prison ☐ Juvenile correctional facility ☐ Local jail (city or county) ☐ State prison ☐ Other correctional facility ☐ Unknown Specify other:	Recently infected with M. tuberculosis (within the past 2 years): ☐ Yes ☐ No ☐ Unknown Skin test conversion - increase of 10mm or more within 2 years: ☐ Yes ☐ No ☐ Unknown
Is the detainee in ICE custody? ☐ Yes ☐ No	TNF-alpha antagonist therapy: ☐ Yes ☐ No ☐ Unknown
Under custody of immigration and customs enforcement: ☐ Yes ☐ No	Other medical risks: ☐ Yes ☐ No ☐ Unknown Specify other:
Incarceration date at diagnosis:	Testing required by employer or school program: ☐ Yes ☐ No
Current resident of long-term care facility: ☐ Yes ☐ No ☐ Unknown	Injecting drug use within past year: ☐ No ☐ Injected drugs ☐ Cocaine ☐ Heroin ☐ Other illicit drug Specify other: Patient was provided additional resources: ☐ Yes ☐ No
Resident of other congregate setting at diagnosis: ☐ Colonia ☐ Displaced citizen ☐ School dorm ☐ Unaccompanied alien child/minor (UAC) ☐ Homeless Shelter ☐ Other Specify other:	Non-injecting drug use within past year: ☐ No ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Crack ☐ Methamphetamines ☐ Other illicit drug Specify other: Patient was provided additional resources: ☐ Yes ☐ No
Employee of high risk congregate setting or institution: ☐ Yes ☐ No ☐ Unknown	
Primary occupation in the past year: ☐ Correctional facility employee ☐ Health care worker ☐ Migrant/seasonal worker ☐ Not seeking employment ☐ Retired ☐ Unemployed ☐ Other ☐ Unknown Specify other:	Tobacco use: ☐ Yes ☐ No Packs per day: Years of use: Patient was provided additional resources: ☐ Yes ☐ No
Correctional facility employee type: ☐ Inmate ☐ Volunteer	Alcohol use: ☐ Yes ☐ No ☐ Unknown In the last 30 days, how many days did the patient consume more than 4 drinks? ☐ 0-4 days ☐ 5 days or more ☐ Unknown Patient was provided additional resources: ☐ Yes ☐ No
Reason not seeking employment: ☐ Child ☐ Disabled ☐ Homemaker ☐ Institutionalized ☐ Student	

Medical risk factor notes:

Last	First	Middle	DOB

Site of Disease

☐ Bone and/or joint	☐ Lymphatic: unknown
☐ Genitourinary	☐ Meningeal
☐ Laryngeal	☐ Peritoneal
☐ Lymphatic: axillary	☐ Pleural
☐ Lymphatic: cervical	☐ Pulmonary
☐ Lymphatic: intrathoracic	☐ Site not stated
☐ Lymphatic: other	☐ Other
Specify other site (anatomic code):	

Other Clinical Information

M. bovis Status	
☐ M. bovis	☐ M. bovis (BCG)
Contact with livestock: ☐ Yes ☐ No ☐ Unknown	History of BCG: ☐ Yes ☐ No
Consumed unpasteurized dairy: ☐ Yes ☐ No ☐ Unknown	Date(s) of BCG:
Information shared with zoonosis: ☐ Yes ☐ No	Receiving BCG as cancer therapy: ☐ Yes ☐ No ☐ Unknown
Date zoonosis notified:	Dates:

Notes

Signature of person taking history Date	Signature of interpreter (if used) Date