



Early TB Prescreen Checklist

Patient Name _____ Date of Birth _____

This is a required screening checklist. Please circle yes to any of the questions that apply. Answering yes does not necessarily indicate that you have TB.

| | | |
|---------------------------------------------------------|-----|----|
| Persistent cough greater than 3 weeks | yes | no |
| Coughing up blood | yes | no |
| Frequent night sweats | yes | no |
| Low-grade fever (100°-101°F) greater than 3 days | yes | no |
| Recent unexplained weight loss with loss of appetite | yes | no |
| Previous Active TB disease | yes | no |
| Chest x-ray suggest rule out TB | yes | no |

In Office Use Only:

Comments for yes responses _____

