

Health questionnaire tuberculosis (TB) screening immigrants < 18 years

This questionnaire is intended for the person who is checked. In young children it is completed by the parents/guardians.

	Yes	No	Unknown
1. Have you ever suffered from tuberculosis (TB)? If Yes; When (year)			
2. Did you ever have a tuberculin skin test (TST) for tuberculosis (TB) performed? If Yes; When (year) What was the result? Positive/ negative/unknown (circle the correct answer)			
3. Did you ever have a blood test for tuberculosis (TB)? If Yes; When (year)..... What was the result? Positive/negative/unknown (circle the correct answer)			
4. Did you receive a BCG vaccination (vaccine for tuberculosis (TB)) If Yes; When (year)			
5. Did you have any other vaccination <u>during the past 6 weeks?</u> If Yes; Name of vaccination When?			
6. Do you have any symptoms? If yes; do you have one or more of the following symptoms?			
– Coughing (longer than 3 weeks)			
– Fever (>38 °C Celsius />100.4 Fahrenheit)			
– Night sweats			
– Weight loss			
– Poor growth/ abnormal growth curve			
7. Have you ever been treated by a specialist? If Yes; what kind of specialist?..... What for?..... When (year)?			
8. Have you ever been tested for HIV? If Yes; when (year)..... What was the result? Positive/ negative/unknown (circle the correct answer)			
9. Are you currently using any medication? If yes; please write names of medication			

The information of this questionnaire is confidential and will be exclusively used for medical purposes. The information will be added to your medical file.

I hereby declare that the above information is true to the best of my ability,

Date: _____

Signature: _____