

TB SKIN TESTING CLIENT INFORMATION SHEET

PREBLE COUNTY GENERAL HEALTH DISTRICT

615 Hillcrest Drive

Eaton, Ohio 45320

INFORMATION REGARDING PERSON RECEIVING TB SKIN TEST

Client Name:	Last	First	Middle Initial	Birthdate	Age	
Address:	Street	City	Preble County	Ohio	Zip	Phone

Family Doctor _____

If the client is a minor, **only** a parent or legal guardian can complete this form and sign it. If you have any questions, we would be happy to help.

Has the person receiving the tuberculosis skin test:

	YES	NO
1. Ever been around anyone with tuberculosis?	()	()
2. Ever had a tuberculosis skin test? If yes, when? _____	()	()
3. Ever had a reaction to a tuberculosis skin test?	()	()
4. Ever been treated for tuberculosis?	()	()
5. Had any of the following symptoms: tiredness, loss of appetite, weight loss, productive cough, low grade fever, and/or night sweats?	()	()
6. Received any immunization shots in the last six weeks?	()	()
7. Had measles, mumps, or chickenpox within the last two months?	()	()
8. Taken any drugs that will lower the body's resistance to infection?	()	()
9. If female, are you pregnant?	()	()

Signature of person to received tuberculosis skin test **OR** person authorized to make the request (parent or guardian):

Signature: _____

Date: _____