West Virginia Department of Health – TB Elimination Program

Diagnostic Clinic Form

(This form is to be filled out for each patient being seen during clinic)

Pt Name: _____ County: _____ Clinic Date: _____

LHD Nurse: _____ *(this should be the person to contact via computer for video clinic)*

Birthdate: _____ Age: _____ Gender: M / F Weight: _____ Allergies: _____

Reason for attending clinic: _____

Pertinent medical history not listed below: _____

HISTORY OF:	YES	NO	HISTORY OF:	YES	NO	HISTORY OF:	YES	NO
TUBERCULOSIS			CARDIOVASCULAR PROBLEMS			GENITO-URINARY PROBLEMS		
BRONCHITIS			SEIZURES			PREGNANCY		
PNEUMONIA			DIABETES			SLEEP PROBLEMS		
ASTHMA			CANCER			HEARING/SPEECH PROBLEMS		
COPD			BONE/JOINT PAIN			BCG VACCINE		
SILICOSIS (Black lung)			IMMUNE SUPPRESSION DRUGS (TNF, steroids, etc.)			IMPAIRED IMMUNE SYSTEM		
TOBACCO USE PPD:_____			ALCOHOL/DRUG ABUSE			LIVER PROBLEMS		

SYMPTOM	YES	NO	EXPLANATION FOR ANY YES ANSWERS
COUGH			
PRODUCTIVE COUGH			
HEMOPTYSIS			
WEIGHT LOSS			
CHEST PAIN			
FATIGUE			
FEVER			
NIGHT SWEATS			

RISK FACTORS	YES	NO	EXPLANATION FOR ANY YES ANSWERS
IMMIGRANT			From: Year came to the U.S.
HIV POSITIVE			
HOMELESS			
CONTACT OF AN ACTIVE CASE			
TRAVEL HISTORY			Where:
OTHER			

CXR: date_____ done by: DTBE___ Other____ Copy of the report was faxed with this form: Yes / No

TST: date_____ size _____ mm IGRA: date_____ type _____ Neg/Pos

Copy of the results was faxed with this form: Yes/No Last known TB test result and date: _____

Page 2 Home medication list completed and faxed with this form: Yes / No If no why not? _____

Occupation: _____ Workplace: _____

Medication Name	Dose	Frequency

Other Important Health Information:

_____

_____

_____

_____

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