October 2024

WV Tuberculosis Elimination Program

X-Ray Record TB-9

Contact to an Active Case:
Yes____ No____

Name of Patient___________________________________ **Occupation**______________________________________

Sex____ **Birthdate**__________ **Address** ____

Name of Physician___________________ **Number of Physician**_______________________________

History of Symptoms:
Temp____ Chest Pain____ Weight Loss____ Cough____ Fatigue____ Night Sweats____ Hemoptysis____

Sputum Positive:
Yes____ No____

Case:
Active TB Disease____ Latent TB Infection____

TB Screening test:
Positive: Yes____ No____ Type of test:______________

Last Menstrual Period:
Date__________________

Impression: **Date of Exam:**____________________

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____ **Name of Clinician:**_______________________

Sputum Still Positive:
Yes____ No____

Last Menstrual Period:
Date__________________

History of Symptoms:
Temp____ Chest Pain____ Weight Loss____ Cough____ Fatigue____ Night Sweats____ Hemoptysis____

Changes as follows: **Date of Exam**:_______________

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____Name of Clinician:_______________________

Sputum Still Positive:
Yes____ No____

Last Menstrual Period:
Date__________________

History of Symptoms:
Temp____ Chest Pain____ Weight Loss____ Cough____ Fatigue____ Night Sweats____ Hemoptysis____

Changes as follows: **Date of Exam**:_______________

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____Name of Clinician:_______________________

Sputum Still Positive:
Yes____ No____

Last Menstrual Period:
Date__________________

History of Symptoms:
Temp____ Chest Pain____ Weight Loss____ Cough____ Fatigue____ Night Sweats____ Hemoptysis____

Changes as follows: **Date of Exam**:_______________

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____Name of Clinician:_______________________