# Annual/Periodic TB Symptom and Risk Assessment: Established Patient with Adequate Prior Treatment

Patient Name:_______________________ Birth Date: _____________ Medical Record #:______________

**TB SYMPTOM AND EXPOSURE REVIEW:**

1. Does patient currently have any of the following symptoms? ☐ Yes ☐ No

☐ cough for more than 3 weeks ☐ coughing up blood ☐ chronic fever
☐ unexplained weight loss ☐ drenching night sweats

2. Since completing treatment for active or latent TB:
   a. Has patient had any contact to someone with known TB disease of the lung? ☐ Yes ☐ No
   b. Has patient traveled to a TB-endemic country (if immunocompromised)? ☐ Yes ☐ No

***IMMEDIATE CHEST X-RAY AND MEDICAL EVALUATION is needed if YES to any of the above***

Person completing the form: ________________________________________ Date: _________________