



### Occupational Health TB Questionnaire

#### SECTION A: TO BE COMPLETED BY PATIENT/EMPLOYEE

DATE: \_\_\_/\_\_\_/\_\_\_

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_

1. Have you previously had a Tuberculin skin test (PPD)?	<input type="checkbox"/> No / <input type="checkbox"/> Yes
2. Do you have a constant productive cough, weight loss (not associated with dieting), fatigue, loss of appetite, and night sweats?	<input type="checkbox"/> No / <input type="checkbox"/> Yes
3. Did you ever have a positive PPD skin test or positive Quantiferon test?	<input type="checkbox"/> No / <input type="checkbox"/> Yes
4. Have you ever received isoniazid (INH) or other TB medications?	<input type="checkbox"/> No / <input type="checkbox"/> Yes
5. Have you received BCG (TB immunization) in the past? (If yes, date: _____)	<input type="checkbox"/> No / <input type="checkbox"/> Yes
6. Have you had MMR or Varicella vaccine within the last 60 days? (If yes, date: _____)	<input type="checkbox"/> No / <input type="checkbox"/> Yes
7. Do you have current or planned immunosuppression, including HIV infection, receipt of an organ transplant, treatment with a TNF-alpha antagonist (e.g., infliximab), chronic steroids (equivalent of prednisone $\geq 15$ mg/day for $\geq 1$ month), or other immunosuppressive medications?	<input type="checkbox"/> No / <input type="checkbox"/> Yes
8. In the past year, have you had temporary or permanent residence (for $\geq 1$ month) in a country with a high TB rate (i.e., any country other than Australia, Canada, New Zealand, the United States, and those in western or northern Europe)?	<input type="checkbox"/> No / <input type="checkbox"/> Yes
9. Since your last TB test, have you had close contact with someone who has had active infectious TB disease?	<input type="checkbox"/> No / <input type="checkbox"/> Yes

*From 11/01/2020 through 10/31/2023, if the answers to questions 7-9 are all (No), annual PPD placement will be waived per the CDPH Approval of Program Flexibility for Title 22 CCR section T22 DIV5 CH1 ART7-70723(b)(3). If there are any (Yes) answers for questions 7-9, then a PPD will still be placed.*

#### SECTION B: FOR USE BY CLINIC ONLY

Date	PPD Given By	Site Given	Solution / Lot #	Read By?	Date/Result
___/___/___	MA LVN RN	<input type="checkbox"/> Left Forearm	<input type="checkbox"/> Tubersol <input type="checkbox"/> Aplisol _____	MA LVN RN MD	___/___/___
		<input type="checkbox"/> Right Forearm			( )mm induration
___/___/___	MA LVN RN	<input type="checkbox"/> Left Forearm	<input type="checkbox"/> Tubersol <input type="checkbox"/> Aplisol _____	MA LVN RN MD	___/___/___
		<input type="checkbox"/> Right Forearm			( )mm induration
If Positive PPD, Date of Last Chest X-ray: _____					
Result: _____					

\*\*Return completed forms to Occupational Health, OR Fax to (714) 456-6540 OR  
Email [healthdoc@hs.uci.edu](mailto:healthdoc@hs.uci.edu) (if emailing outside UC Irvine or [healthdoc@uci.edu](mailto:healthdoc@uci.edu) if emailing from within UC Irvine)