



TB SKIN TEST (P.P.D.) QUESTIONNAIRE & CONSENT

Date: _____ Name: _____ DOB: _____

You will be given a skin test for Tuberculosis. Circle one answer below.

- 1.) Have you had a TB skin test in the past? **Y N**
- 2.) If yes, were you told it was “positive” or was there any redness or swelling? **Y N**
- 3.) Have you ever had a BCG vaccine (given in countries outside of the U.S.?) **Y N**
- 4.) Have you or any of your family members been exposed to active TB? **Y N**
- 5.) Have you had a viral illness or received any vaccinations in the past four (4) weeks? **Y N**
- 6.) Do you currently take cancer medicine or steroids? **Y N**
- 7.) Are you pregnant or nursing*? **Y N**

IF YOU ARE PREGNANT OR NURSING, YOU WILL NEED PERMISSION FROM YOUR PHYSICIAN PRIOR TO TAKING THIS TEST

By signing below, I am acknowledging that I have been given information and an opportunity to ask questions about PPD TB skin test, and now consent to receiving the test.

Patient Signature _____ Date _____

*****PLEASE BE AWARE, you MUST return to the office after 48-72 hours to check the area for a positive or negative reading. After the 72 hours has expired the test now becomes invalid and another PPD TB skin test will need to be performed*****