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| **HEALTH QUESTIONNAIRE TUBERCULOSIS (TST/IGRA)** *This questionnaire is intended for the person who is checked.* | **Yes** | **No** | **Unknown** |
| 1. **Have you ever suffered from tuberculosis (TB)?** If yes, when (year)?................................................................................................................... |  |  |  |
| 1. **Did you ever have a tuberculin skin test (TST) for tuberculosis (TB) performed?** If yes, when (year)?..................................................... Result: positive / negative / unknown |  |  |  |
| 1. **Did you ever have a blood test for tuberculosis (TB)?** If yes, when (year)?..................................................... Result: positive / negative / unknown |  |  |  |
| 1. **Did you receive a BCG vaccination (vaccine for tuberculosis)?** If yes, when?............................................................................................................................. |  |  |  |
| 1. **Did you have any other vaccination during the past 6 weeks?** If yes, name of the vaccine and when?.................................................................................... |  |  |  |
| 1. **Do you have any health complaints?** If yes, do you have one or more of the following symptoms? |  |  |  |
| - Coughing (longer than 3 weeks) |  |  |  |
| - Fever ( > 38.0 °C / >100.4 Fahreneit) |  |  |  |
| - Night sweats |  |  |  |
| - Weight loss |  |  |  |
| - Poor growth / abnormal growth curve |  |  |  |
| 1. **Have you ever been treated by a specialist?** If yes, what kind of specialist? .................................................................................................. What for? ................................................................................................................................. When? ...................................................................................................................................... |  |  |  |
| 1. **Have you ever been tested for HIV?** If yes, when (year)? ………………………….. What was the result? positive / negative / unknown |  |  |  |
| 1. **Are you currently using any medication?** If yes, which medication?.......................................................................................................... |  |  |  |