Staff Assigned: _____

Southern Nevada Health District

Tuberculosis Treatment and Control Clinic
New Client Information Form

Contact/Personal Information:

Today's Date: _____

Last Name:	**First Name:**	**Middle:**	**Date of Birth:**	**Sex:** ☐ Male ☐ Female
Address (and Apt#):		**City:**	**State:**	**ZIP Code:**
Home#:	**Cell#:**	**Work#:**	**Email:**	
Country of Birth	**If foreign born, date of entry into the US:**	**State/Province of Birth**	**City of Birth**	

Race (please check all that apply):
☐White ☐Black and/or African American ☐American Indian and/or Alaska Native
☐Asian ☐Native Hawaiian and/or Other Pacific Islander ☐Unknown ☐Decline

Ethnicity (please check): **Do you have a Hispanic Background?** ☐Yes ☐No ☐Unknown ☐Decline	**Language first spoken:** **Language most comfortable speaking:**
Marital Status (please check): ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed	**Do you need an interpreter?** ☐Yes ☐No **If yes, what language?**

Name of Employer:	**Job Title:**	**Name of School:**

Emergency Contact:

Name:	**Relationship to You:**	**Place of Employment:**	
Address (and Apt#):	**City:**	**State:**	**ZIP Code:**
Home#:	**Cell#:**	**Work#:**	**Other#:**

Reason for Today's Visit:

☐ Continuation of Care: ☐ Active TB ☐ Suspect ☐ TB Infection	☐ Other, please specify:
☐ Employer Referral	
☐ Further Tests	
☐ Health Card Referral	
☐ Immigration/Refugee/Change of Status	

Previous Testing, Exposure, Disease, or Treatment:

Have you ever been tested for tuberculosis? ☐ Yes ☐ No	**Reason for most recent TB test?**	
What type of test was done? ☐ Skin ☐ Blood ☐ Chest X-Ray	**Date of skin/blood test:**	**Result of the skin/blood test:** ☐ Positive ☐ Negative
Date of Chest X-ray:	**Chest X-Ray done at:**	**Result of Chest X-Ray:**
Have you ever been diagnosed with Tuberculosis Infection or Disease? ☐ Yes ☐ No		
If yes, when and where?		**Type of treatment taken:**
Have you ever been exposed to Tuberculosis? ☐ Yes ☐ No		**If yes, when and where?**

Symptom Screen, Medical and Risk Factor Review

Check any of the following you have recently experienced:			
☐ Cough	☐ Chest Pain	☐ Chills	☐ Fatigue/Malaise
☐ With Phlegm	☐ Fever	☐ Hoarseness	☐ Loss of Appetite
☐ With Blood	☐ Loss of Weight	☐ Night Sweats	☐ Shortness of Breath
☐ Other (specify):		When did these symptoms start?	

Check all that apply		
Medical Risk	☐ <10% below ideal weight	☐ Immunosuppressive Therapy
	☐ Autoimmune Disease	☐ Injecting Drug Use
	☐ Cancer (specify):	☐ Non-injecting Drug Use
	☐ Diabetes: ☐ Type 1 ☐ Type 2	☐ Organ Transplant Recipient
	☐ Dialysis/Renal Failure	☐ Rheumatoid Arthritis
	☐ Excessive Alcohol Use	☐ Silicosis
	☐ Gastrectomy/Intestinal Bypass	☐ Smoker: ☐ Cigarette ☐ Cigar ☐ Hookah
	☐ HIV Infection	Packs per day: _____ Years: _____
	☐ Other Immune/Chronic Disease (specify):	☐ Other recent medical/surgical history (specify):
Population Risk	☐ Child exposed to high risk adult	☐ Long-term care facility employee
	☐ Foreign-born in USA <5 years	☐ Long-term care facility resident
	☐ Health care employee	☐ Marginally housed/ Couch surfing
	☐ Homeless shelter employee	☐ Migratory agricultural worker
	☐ Homeless shelter resident	☐ Prison/jail/juvenile hall inmate
	☐ Homeless not residing in shelter	☐ Prison/jail employee
	☐ Other (specify):	

Please list medications (prescribed and/or over the counter), vitamins, and/or supplements you take. Include dose and frequency, if known:

Current Health Care Provider(s), indicate specialty if known:

Do you have health insurance? ☐ Yes ☐ No

Name of health insurance:

Clinic Staff Use Only

Interviewed By:			Date:
☐ Change of Status	☐ Class B Immigrant	☐ Contact: Investigator Assigned _____	
☐ Employee Health	☐ Health Cards	☐ In Contact Investigation (CI) Form	
☐ Hospital Referral	☐ Recently Incarcerated	☐ 1st Round Info in CI Form	
☐ Refugee	☐ Suspect/Active	☐ 2nd Round Info in CI Form	
PPD Date:	QFT Date:		X-Ray Date:
PPD Result:	QFT Result:		X-Ray Result
Window Prophylaxis Candidate:	Window Prophylaxis Status		Window Prophylaxis Start Date:
☐ Yes ☐ No	☐ Accept ☐ Decline		
2nd PPD Date:	2nd QFT Date:		2nd X-Ray Date:
2nd PPD Result:	2nd QFT Result:		2nd X-Ray Result:
Further Tests ☐ Yes ☐ No	If yes, describe:		
LTBI Candidate:	☐ Yes ☐ No		