

**Texas Department of State Health Services  
Clinical Assessment for Tuberculosis Medication Toxicity**

NAME: \_\_\_\_\_ D.O.B.: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS#: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

<b>Adverse Drug Reaction Assessment:</b>											
Ask questions (1-18) when patient is on first-line drugs and ask questions (1-28) if any second-line drugs are added to patient's regimen. Document [+] results in the progress notes and notify the physician. Notify physician if a woman of childbearing age indicates that she thinks she may be pregnant or has signs of pregnancy.											
<b>Results: [ + ] = If Present [ - ] = If Denies [ NA ] = If Not Applicable</b>											
	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
Weight											
Temperature											
Blood Pressure											
<b>Do you have any of the following symptoms now or since your last clinic appointment?</b>											
1. Loss of Appetite											
2. Nausea/Vomiting											
3. Urine Color Change (Dark)											
4. Skin Rashes/Dry											
5. Numbness/Tingling (Hands/Feet, Face/Mouth)											
6. Change in Vision*											
7. Eye Pain/Irritation (Redness, Excessive Tears)											
8. Jaundice (Yellow Skin/Eyes)											
9. Flu-like Symptoms											
10. Fatigue											
11. Headaches											
12. Fever											
13. Joint Pains/Swelling											
14. Urine Output ↓											
15. Bleeding (Nose Bleeds, Hemoptysis)											
16. Vertigo/Dizziness/Fainting											
Teeter/Fall to Left or Right When Standing (With Eyes Closed)											
Weave/Stagger When Walking (Normal Gait)											
17. Hearing Loss/Ears Ringing/Fullness											
18. Nervousness/Giddiness/Restlessness											
19. Increased Gas/Stomach Cramps											
20. Abdominal Pain/Diarrhea											
21. Sleep Problems											
22. Mood Changes/Depression											
23. Change in Heart Rate											
24. Convulsions											
25. Memory Loss											
26. Abnormal Behavior											
27. Skin Discoloration											
28. Allergic Reaction											
<b>Ask about use of over the counter medications such as Tylenol, etc.</b>											
<b>Ask women about signs of pregnancy.</b>											
<b>Drug Issued</b>	<b>Mfg/Lot#/Exp</b>	<b>Route/ Frequency</b>	<b>Amt. Given</b>								
<b>Initials**/Title</b>											
<b>Interpreter</b>											
<b>Next Appt.</b>											

\* Changes in Vision may include blind spots in field of vision, blurred vision, changes in peripheral vision

\*\* See Provider Signature Sheet



## Texas Department of State Health Services Vision/Hearing Screening Form

NAME: \_\_\_\_\_

**Red/Green Color Discrimination:**

The (X) mark indicates the plate cannot be read. Screen all 14 plates. Client must pass 10 of the first 11 plates for the test to be regarded as normal. Refer for evaluation if  $\leq 7$  plates are read as normal.

Results: 1 N 1 = Normal 1 A 1 = Abnormal

Ishihara Plate #	Normal Reading	Red/Green Deficiency	Date		Date		Date		Date		Date		Date	
1	12	12												
2	8	3												
3	5	2												
4	29	70												
5	74	21												
6	7	X												
7	45	X												
8	2	X												
9	X	2												
10	16	X												
11	Traceable	X												
		<b>Protan</b>	<b>Deutan</b>											
		<b>Strong</b>	<b>Mild</b>	<b>Strong</b>	<b>Mild</b>									
12	35	5	(3) 5	3	3 (5)									
13	96	6	(9) 6	9	9 (6)									
14	Can trace 2 lines	Purple	Purple (Red)	Red	Red (Purple)									
<b>Results</b>														
<b>Initials</b>														

**Visual Acuity:**

If initial screen was conducted with corrective lenses (glasses or contacts), follow-up screens must be done the same. A change of 1 or more lines from the initial screen in either one or both eyes must be reported to the physician immediately.

Results: [ P ] = Pass [ F ] = Fail [ U ] = Unscreenable Chart Used: [ ] Letter [ ] "E" [ ] Other, Specify: \_\_\_\_\_

Corrective Lenses: [ ] = Yes [ ] = No

Distance Acuity	Date									
Right Eye	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/
Left Eye	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/
Both Eyes	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/
<b>Results</b>										
<b>Initials</b>										

**Hearing Sweep Check:**

When patient is taking amikacin, capreomycin, kanamycin, or streptomycin, for each of the four frequencies listed, record the lowest level in decibels (dB) at which the person responds. Record the findings for both the right and left ear. Refer to an appropriately licensed professional if any two of the four frequencies are recorded as greater than 25 dB in either ear or the same ear or if there is a change of decreased hearing level from baseline. Start with 40 dB, if heard decrease by 10 dB until no response is obtained or until 20 dB is reached. If 20 dB is heard, record as 20 dB. Once no response is obtained, increase the dB level by 5 until a response is obtained and recorded. If a response is not heard at 40 dB, record as 40+ dB.

Results: [ P ] = Pass [ R ] = Refer [ O ] = Observe Ear: [ R ] = Right [ L ] = Left

Frequency	Date															
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L
500 Hz																
1000 Hz																
2000 Hz																
4000 Hz																
<b>Initials</b>																