Texas Department of State Health Services

Tuberculosis Initial Health Risk Assessment/History

SSN	Medicaid#	DOB	Sex at Birth	Phone 1
Last	**First**	**Middle**		**Phone 2**
Street Address	**City**	**County**	**State**	**Zip**

Additional Patient Information

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ UNK

Race: ☐ American Indian or Alaska Native ☐ Asian, specify: ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander, specify: ☐ White ☐ Other race, specify: ☐ UNK

ATS Classification

☐ 0-No M. TB exposure, not infected	☐ 3-M. TB disease, clinically active
☐ 1-M. TB exposure, no evidence of infection	☐ 4-Previous M. TB disease, not clinically active
☐ 2-M. TB infection, no TB disease	☐ 5-M. TB suspect, diagnosis pending

Initial Report and Assessment

How was the patient first reported to the health department: ☐ Contact investigation ☐ Electronic disease notification (EDN) referral ☐ Electronic lab report (ELR) ☐ Genotyping ☐ Hospital referral ☐ Interjurisdictional notification (IJN) ☐ Private Provider referral ☐ Targeted testing ☐ Vital statistics ☐ Walk-in ☐ Other, specify:

Initial reason evaluated for TB: ☐ Contact investigation ☐ Screening ☐ TB symptoms ☐ Other ☐ UNK

Date of initial assessment: | Assessment conducted by:

Location of the assessment: ☐ Health department ☐ Correctional facility ☐ Hospital ☐ Long term care facility ☐ Private outpatient clinic ☐ Other, specify (e.g., patient home):

Vital Status and Country of Origin

Status at diagnosis (*confirmed TB cases only*): ☐ Alive ☐ Dead

Country of birth:
If not U.S., date of first U.S. arrival:

Eligible for U.S. Citizenship/Nationality at Birth (regardless of county of birth): ☐ Yes ☐ No ☐ UNK

Country of birth for primary guardian(s) (for pediatric TB patients <15 years old cases only):
Guardian 1: Guardian 2: Relationship of primary guardian:

Country of usual residence:
If not U.S. reporting area, has been in the U.S. for ≥90 days (inclusive of report date)? ☐ Yes ☐ No ☐ UNK

Foreign Birth or Travel

Immigration status at first entry to the US: ☐ Not applicable ☐ Immigrant visa ☐ Student visa ☐ Employment visa ☐ Tourist visa ☐ Family/fiancé visa ☐ Refugee ☐ Asylee or parolee ☐ Other immigration status ☐ UNK
Specify other:

Notice of arrival of alien with TB class (EDN): ☐ A ☐ B1 ☐ B2 ☐ B3 | Alien number:

Residence or travel in country with high prevalence of TB in last 2 years: ☐ Yes ☐ No | Country:

Date of travel: | Approximate length of stay/residence:

Has the patient traveled for 8 consecutive hours while symptomatic? ☐ Yes ☐ No | Method of transportation: ☐ Flight ☐ Bus ☐ Train ☐ Ship/boat Specify:

Comments:

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Previous History of TB and Latent TB Infection (LTBI)

Has the patient been previously diagnosed with TB disease or LTBI: ☐ TB Disease ☐ LTBI ☐ No ☐ UNK

History: ☐ Documented ☐ Self-reported	Previous TB occurred in U.S.: ☐ Yes ☐ No
State/Country of previous TB disease or TB infection:	Previous state case number (if reported in Texas after 1993):
Date of previous diagnosis:	More than one previous episode: ☐ Yes ☐ No ☐ UNK
Start date previous TB treatment: Stop date previous TB treatment: Previous TB drug regimen/Dosage (mg): Previous TB treatment documented: ☐ Yes ☐ No ☐ UNK Completed treatment?: ☐ Yes ☐ No ☐ UNK	Start date previous LTBI treatment: Stop date previous LTBI treatment: Previous LTBI drug regimen/Dosage (mg): Previous LTBI treatment documented: ☐ Yes ☐ No ☐ UNK Completed LTBI treatment?: ☐ Yes ☐ No ☐ UNK
Previous positive IGRA: ☐ Yes ☐ No ☐ UNK ☐ QFT ☐ T-SPOT Date Collected: Date Reported:	Previous imaging type: ☐ Plain CXR ☐ CT Scan ☐ MRI ☐ PET ☐ Other Previous imaging date:
Previous positive TST: ☐ Yes ☐ No ☐ UNK Induration: mm Date Administered: Date Read:	Result: ☐ Consistent with TB ☐ Not consistent with TB ☐ Not done ☐ UNK Cavitary: ☐ Yes ☐ No ☐ UNK

Epidemiologic Investigation

Case identified during the contact investigation of another case?: ☐ Yes ☐ No ☐ UNK	If yes: Evaluated for TB during that contact investigation? ☐ Yes ☐ No ☐ UNK	
Date:	☐ Greater than 2 years ☐ Less than or equal to 2 years	Relationship to patient:
Contact Investigation conducted for this case?: ☐ Yes ☐ No ☐ UNK	Comments:	

Symptoms

TB symptoms screening performed: ☐ Yes ☐ No | Is patient symptomatic: ☐ Yes ☐ No ☐ UNK

Symptom Screening Date:

Symptom		***Date of Symptom Onset***	***Symptom***		***Date of Symptom Onset***
Bloody urine:	☐ Yes ☐ No		Headache:	☐ Yes ☐ No	
Chest pain:	☐ Yes ☐ No		Hemoptysis:	☐ Yes ☐ No	
Cough/persistent x 3 weeks:	☐ Yes ☐ No		Loss of appetite:	☐ Yes ☐ No	
Decreased level of consciousness:	☐ Yes ☐ No		Neck stiffness:	☐ Yes ☐ No	
Enlarged cervical lymph nodes:	☐ Yes ☐ No		Night sweats:	☐ Yes ☐ No	
Eye pain or blurry vision:	☐ Yes ☐ No		Pain, swelling other locations:	☐ Yes ☐ No	
Fatigue:	☐ Yes ☐ No		Productive cough:	☐ Yes ☐ No	
Fever/chills:	☐ Yes ☐ No		Swelling of joint/vertebrae:	☐ Yes ☐ No	
Flank pain:	☐ Yes ☐ No		Swelling of lymph nodes:	☐ Yes ☐ No	
Frequent urination:	☐ Yes ☐ No		Weight loss >10%:	☐ Yes ☐ No	

Other, Specify other:

Source of symptom information: ☐ Patient interview ☐ Relative/friend ☐ Medical record ☐ Other, specify:	Respiratory isolation indicated: ☐ Yes ☐ No Date placed in respiratory isolation:

Notes:

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Clinical		
Date of clinical assessment:		
Weight: lbs kgs	Height: ft in cm	BMI:
Estimated weight, 3 months ago: lbs kg	Weight at least 10% < ideal body weight: ☐ Yes ☐ No	
Blood pressure: systolic diastolic		
Date temperature collected:	Temperature: F C	

Medical Risk and History	
Date medical history collected:	**Comments**
Allergies: ☐ Yes ☐ No ☐ UNK	
Arthritis/gout: ☐ Yes ☐ No ☐ UNK Use of ☐ Remicade ☐ Humira ☐ Enbrel	
Autoimmune: ☐ Yes ☐ No ☐ UNK	
Cancer: ☐ Yes ☐ No ☐ UNK Specify: ☐ Head ☐ Neck ☐ Other, specify:	
Chronic malabsorption syndrome: ☐ Yes ☐ No ☐ UNK	
Chronic renal disease: ☐ Yes ☐ No ☐ UNK	
Corticosteroids (received equivalent of >15 mg/d Prednisone for >1 month): ☐ Yes ☐ No ☐ UNK	
Covid-19 at TB diagnostic evaluation? ☐ Yes ☐ No ☐ UNK	
Diabetic at TB diagnostic evaluation? ☐ Yes ☐ No ☐ UNK	☐ Documented ☐ Self-reported
Diabetes controlled: ☐ Yes ☐ No ☐ UNK	Controlled through: ☐ Pills ☐ Insulin ☐ UNK
Diabetic mellitus: ☐ Yes ☐ No ☐ UNK	☐ Type 1 ☐ Type 2
End-stage renal disease: ☐ Yes ☐ No ☐ UNK	
GI/gastrectomy or jejunoileal bypass: ☐ Yes ☐ No ☐ UNK	
Gynecological: ☐ Yes ☐ No ☐ UNK	
Heart disease/PVD: ☐ Yes ☐ No ☐ UNK	
Hemodialysis: ☐ Yes ☐ No ☐ UNK	Schedule:
HIV/AIDs: ☐ Yes ☐ No ☐ UNK	
Hypertension/CVA: ☐ Yes ☐ No ☐ UNK	
Intellectual disability/developmental delay: ☐ Yes ☐ No ☐ UNK	
Mental illness(es): ☐ Yes ☐ No ☐ UNK Specify: ☐ Anxiety ☐ Depression ☐ Schizophrenia ☐ UNK ☐ Other, specify:	When (select all that apply): ☐ Currently ☐ Within past 12 months ☐ Ever
Neurological/seizures: ☐ Yes ☐ No ☐ UNK	
Other immunocompromise (Other than HIV/AIDS): ☐ Yes ☐ No ☐ UNK Specify:	
Other liver disease (not hepatitis B or C): ☐ Yes ☐ No ☐ UNK	
Post-organ transplantation: ☐ Yes ☐ No ☐ UNK	
Postpartum: ☐ Yes ☐ No ☐ UNK	
Respiratory problems: ☐ Yes ☐ No ☐ UNK	
Silicosis: ☐ Yes ☐ No ☐ UNK	
Skin disease: ☐ Yes ☐ No ☐ UNK	
STD: ☐ Yes ☐ No ☐ UNK	
Surgeries/hospitalizations: ☐ Yes ☐ No ☐ UNK	
Thyroid: ☐ Yes ☐ No ☐ UNK	
TNF-alpha antagonist therapy: ☐ Yes ☐ No ☐ UNK	
Viral hepatitis (B or C Only): ☐ Yes ☐ No ☐ UNK	
Vision/hearing disorder: ☐ Yes ☐ No ☐ UNK	
Skin test conversion – increase of 10mm or more within 2 years ☐ Yes ☐ No ☐ UNK	
Incomplete LTBI therapy: ☐ Yes ☐ No ☐ UNK	
Untreated or inadequately treated active TB, including fibrotic changes on X-ray consistent with previous TB: ☐ Yes ☐ No ☐ UNK	
Recently infected with M. tb (within the past 2 years): ☐ Yes ☐ No ☐ UNK	

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Primary Care or Specialty Care		
Primary care provider: ☐ Yes ☐ No	Name of primary care provider:	Phone:
Specialty care provider: ☐ Yes ☐ No		
Specialty type: ☐ Pulmonologist ☐ Infectious disease ☐ Internal medicine ☐ Neurologist ☐ Other Specify other:	Name of specialty care provider: Phone:	
HIV Status		
Specimen source: ☐ Blood ☐ Other, specify:		
Collection Date:	Date Reported:	
HIV status results: ☐ Indeterminate ☐ Negative ☐ Not done ☐ Not offered ☐ Positive ☐ Refused ☐ Test done-results UNK ☐ UNK	City/County HIV#:	
CD4 count, if HIV+:	Date, if HIV+:	
HIV counseling and referral provided: ☐ Yes ☐ No		

Medications taking (excluding TB drugs)				
Medication	Start date	Dosage/schedule	Stop date	Prescribing Provider/Facility
(Attach additional medication list, if needed)				
Name of person taking history:				
Name of interpreter (if used):				
Barriers to compliance: ☐ Yes ☐ No	Comments:			
Live virus immunization in last 6 weeks: ☐ Yes ☐ No Date:				
Immunizations received: ☐ FluMist (influenza) ☐ MMR (measles, mumps, rubella) ☐ MMRV (measles, mumps, rubella, varicella) ☐ Rotavirus ☐ Herpes zoster (shingles) ☐ Smallpox ☐ Varicella ☐ Yellow fever ☐ Covid-19				

Pregnant/Pregnancy ☐ Female ☐ Not applicable	
Pregnant at time of diagnostic evaluation?: ☐ Yes ☐ No ☐ UNK	If no, patient pregnant within year previous to diagnosis: ☐ Yes ☐ No ☐ UNK
If yes, as of (date):	Outcomes(s): ☐ Live birth ☐ Miscarriage ☐ Still birth ☐ Termination ☐ Other Specify other:
Due date:	Outcome date:
Placenta evaluated: ☐ Yes ☐ No	Term delivery: ☐ Yes ☐ No ☐ UNK
Pregnancy clinical notes:	Baby evaluated for TB: ☐ Yes ☐ No ☐ UNK Evaluation result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Other ☐ UNK Specify other: Outcome of evaluation: ☐ TB infection ☐ TB infection window period ☐ TB suspect ☐ TB disease ☐ No TB disease or infection
	Live birth facility:
	Did anyone in the patient's household have a baby in the last 3 months? ☐ Yes ☐ No ☐ UNK

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Social Risk Factors	
Date social risk factors collected:	**Comments**
Heavy alcohol use in the past 12 months: ☐ Yes ☐ No ☐ UNK In the last 30 days, how many days did the patient have > 4 drinks? ☐ 0-4 days ☐ 5 days or more ☐UNK	Patient was provided additional resources: ☐ Yes ☐ No
Injecting drug use in the past 12 months: ☐ Yes ☐ No ☐ UNK If yes, specify: ☐ Cocaine ☐ Opioids ☐ Other illicit drug Other:	Patient was provided additional resources: ☐ Yes ☐ No
Non-injecting drug use in the past 12 months: ☐ Yes ☐ No ☐ UNK If yes, specify: ☐ Marijuana ☐ Cocaine ☐ Opioids ☐ Crack ☐ Methamphetamines ☐ Other illicit drug Other:	Patient was provided additional resources: ☐ Yes ☐ No
Current smoking status at diagnostic evaluation: ☐Current every day ☐ Current someday ☐ Former ☐ Never ☐Current status UNK ☐ UNK if ever Packs per day/Years of use:	Patient was provided additional resources: ☐ Yes ☐ No
Homeless in the past 12 months: ☐ Yes ☐ No ☐ UNK	
Homeless ever: ☐ Yes ☐ No ☐ UNK	
Resident of correctional facility at diagnostic evaluation: ☐ Yes ☐ No ☐ UNK Type of correctional facility: ☐ Federal prison ☐ State prison ☐ Local jail (city or county) ☐ Juvenile correctional facility ☐ Other: ☐ UNK	
Under custody of immigration and customs enforcement (ICE): ☐ Yes ☐ No ☐ UNK	
Resident of correctional facility ever: ☐ Yes ☐ No ☐ UNK	
Resident of long-term care facility at diagnostic evaluation: ☐ Yes ☐ No ☐ UNK If Yes, type of long-term care facility: ☐ Nursing home ☐ Hospital-based facility ☐ Residential facility ☐ Mental health residential facility ☐ UNK ☐ Alcohol or drug treatment facility ☐ Other, specify:	
Resident of other congregate setting at diagnostic evaluation: ☐ Yes ☐ No ☐ UNK If yes, specify: ☐ Colonia ☐ Displaced citizen ☐ School dorm ☐ Unaccompanied alien child/minor (UAC) ☐ Homeless Shelter ☐ Other, specify ☐ UNK	
Low income: ☐ Yes ☐ No ☐ UNK	
Inner-city resident: ☐ Yes ☐ No ☐ UNK	
Patient lived outside US for >2 months (uninterrupted): ☐ Yes ☐ No ☐ UNK Countries:	
Employee of high risk congregate setting or institution: ☐ Yes ☐ No ☐ UNK	
Has the patient ever worked as one of the following: ☐ Healthcare worker ☐ Correctional facility employee ☐ Migrant/ seasonal worker ☐ None of the above ☐UNK ☐ Other, specify	
Current Occupation for all patients ≥14 years of age: Current industry:	
Contact to infectious TB patient (2 years or less): ☐ Yes ☐ No ☐ UNK	
Contact to MDR-TB case (2 years or less): ☐Yes ☐No ☐UNK	

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Site of Disease	
☐ Pulmonary (lung) ☐ Pleural ☐ Lymphatic: cervical ☐ Lymphatic: intrathoracic ☐ Lymphatic: axillary ☐ Lymphatic: other ☐ Lymphatic: UNK	☐ Laryngeal ☐ Bone and/or joint ☐ Genitourinary ☐ Meningeal ☐ Peritoneal ☐ Site not stated ☐ Other (specify):
Specify other site (anatomic code):	

M. *bovis* Risk Factors	
Exposure or contact with livestock: ☐ Yes ☐ No ☐ UNK Consumed unpasteurized dairy: ☐ Yes ☐ No ☐ UNK	BCG vaccination given: ☐ Yes ☐ No ☐ UNK Date(s) of BCG: Receiving BCG as cancer therapy: ☐ Yes ☐ No ☐ UNK Dates:

Notes	
Signature of person taking history Date	Signature of interpreter (if used) Date