Patient Name: _____ Birthdate:_____ Date:_____

Primary Care Associates
Risk Screening Questionnaire for Exposure to Latent Tuberculosis Infection

Please circle your answers. Thank you.

1. Has a family member or contact had tuberculosis? Yes No

2. Has a family member had a positive tuberculin skin test? Yes No

3. Was your child born in a high-risk country (countries other than the United States, Canada, Australia, New Zealand, or Western Europe? Yes No

4. Has your child traveled (had contact with resident populations) to a high-risk country for more than 1 week? (High Risk Countries/Continents would include Mexico, Central America, South America, Africa, and Asia) Yes No