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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)?...................................................................................................................
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| 1. **Did you ever have a tuberculin skin test (TST) for tuberculosis (TB) performed?**If yes, when (year)?..................................................... Result: positive / negative / unknown
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| 1. **Did you ever have a blood test for tuberculosis (TB)?**If yes, when (year)?..................................................... Result: positive / negative / unknown
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| 1. **Did you receive a BCG vaccination (vaccine for tuberculosis)?**If yes, when?.............................................................................................................................
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| 1. **Did you have any other vaccination during the past 6 weeks?**If yes, name of the vaccine and when?....................................................................................
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| 1. **Do you have any health complaints?**If yes, do you have one or more of the following symptoms?
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| - 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? ......................................................................................................................................
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| 1. **Have you ever been tested for HIV?**If yes, when (year)? ………………………….. What was the result? positive / negative / unknown
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| 1. **Are you currently using any medication?**If yes, which medication?..........................................................................................................
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