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Patient Label

**TUBERCULOSIS SKIN TEST QUESTIONNAIRE**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employee Number (if applicable): \_\_\_\_\_ Department: \_\_\_\_\_

Allergies:  No known allergies List: \_\_\_\_\_

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Please answer the following questions by checking "Yes" or "No" and filling in the blanks:

1. Have you ever had a **positive** tuberculin skin test (TST, PPD, or Mantoux)?  No  Yes

\* If **NO**, skip to question #6

\* If you answered **YES** to question #1, please fill out Tuberculosis Symptom Review form and the following questions. **You should not receive a PPD if you have previously tested positive.**

2. What year was the positive test? \_\_\_\_\_

3. Test reaction in millimeters (if known) \_\_\_\_\_ mm  Unknown

4. When was your last chest x-ray? \_\_\_\_\_

5. Did you ever take medication for a positive tuberculin test?  No  Yes

If **YES**, name of medication: \_\_\_\_\_

How long were you on this medication?: \_\_\_\_\_

6. Have you ever had an **allergic reaction** to TB skin testing?  No  Yes

7. Have you received a tuberculin skin test/PPD in the past 12 months?  No  Yes

If **YES**, when: \_\_\_\_\_

What was the result:  Negative  Positive ( \_\_\_\_\_ mm)

8. Have you ever received BCG vaccine (*Bacillus Calmette-Guérin*) to prevent tuberculosis?

No  Yes If **YES**, approximate date: \_\_\_\_\_

**\*\*\*\* Please note: the TST/PPD must be read within 48 to 72 hours of placement or it must be repeated \*\*\*\***

Patient Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_\_\_

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**TUBERCULOSIS SKIN TESTING:**

Placed on: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_\_\_ Placed on:  Left Forearm  Right Forearm

Lot #: \_\_\_\_\_ Expiration Date: \_\_\_/\_\_\_/\_\_\_

Placed by: \_\_\_\_\_

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**TST/PPD must be read within 48 to 72 hours of placement** Read on: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_\_\_

Result:  Negative ( \_\_\_\_\_ mm)

Positive ( \_\_\_\_\_ mm) Any result other than "negative" requires patient to report to Bayhealth Occupational Health for further examination within 2 business days.

Read by: \_\_\_\_\_ Facility: \_\_\_\_\_

(Please print and include credentials) Phone number: \_\_\_\_\_