Huntington Hospital
Medical Staff Tuberculosis Status Record

Physician Name: _____
(Please Print)

Please answer the following questions:	**Yes**	**No**
1) Have you ever had a positive (reactive) TB skin test? **If "YES", specify date ___/___/___ and attach a copy of Positive results.**		
2) In the last two months have you had vaccination for polio or measles?		
3) Do you currently take cortisone/steroid medications?		
4) Have you ever been treated for Tuberculosis with the medication Isoniazid (INH)?		
5) Have you ever received a BCG vaccination for Tuberculosis? **** A history of BCG vaccination is not a contraindication for testing ****		
6) Have you ever been diagnosed with Tuberculosis?		
7) Do you have any of the following:		
a) Cough lasting longer than 3 weeks?		
b) Coughing up blood?		
c) Fever lasting longer than 3 weeks?		
d) Night Sweats?		
e) Unintentional Weight Loss?		

_____ _____
Physician Signature **Date**