Four Corners Primary Care Center
5030 Georgia Belle Court
Norcross, Georgia 30093

DATE ______________________

PATIENT NAME __________________________________ DOB ____________________

PT# ________________________

Tuberculosis (TB) Risk Assessment

Circle Yes or No

1.	Is the child in close contact to a person sick or with active TB disease?	Yes	No
2.	Does the child have or is the child at risk to have HIV?	Yes	No
3.	Was the child or the child's parent born outside the US?	Yes	No
4.	Is the child exposed to a person in jail or a person who has been in jail in the past five years?	Yes	No
5.	Is the child exposed to a person who has IHV, who is homeless or who lives in nursing home of another group home?	Yes	No
6.	Is the child exposed to drug users or migrant farm workers?	Yes	No
7.	Does the child have a health problem that lowers the Immune System?	Yes	No
8.	Does the child live in a community that has a high risk for TB?	Yes	No
9.	Has the child traveled to or had a visitor from any foreign country since the last visit?	Yes	No
10.	Does the child have any symptoms of TB (sough, fever, night sweats, loss of appetite, weight loss, or fatigue) or an abnormal chest X-ray?	Yes	No