Pediatric & Adult Medicine, Inc.
A Member of CHOC Children's Network

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Patient's Name: _____

Patient's Date of Birth: _____

Tuberculosis Screening

1. Was your child born in or traveled/resided in a country with an elevated tuberculosis rate **for at least 1 month?**
   This includes ANY country other than USA, Canada, Australia, New Zealand or a country in western or northern Europe.

   ☐ **Yes** ☐ **No**

2. Has your child been under medical care related to a significant suppression of his/her immune system? For example: organ transplant, HIV infection or prolonged steroid use.

   ☐ **Yes** ☐ **No**

3. Has your child had close contact with someone with infectious tuberculosis during his/her lifetime?

   ☐ **Yes** ☐ **No**

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Board Certified
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