**TB Clinic** **Follow-up Visit**

Insert HD Logo here

Patient Label

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of History Time of History Primary Care Provider Phone Number of Primary Care Provider

Eye Exam OD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OU \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ISHIHARA\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SIGNS & SYMPTOMS OF TB**  **+ = Positive History**  - **= Negative History** | **+/-** | **DATE OF ONSET IF NEW** | **IMPROVED**  **+/-** | **COMMENTS** |
| Cough |  |  |  |  |
| Weight Loss |  |  |  | Today’s Wt.\_\_\_\_\_\_\_\_\_ |
| Fever/Chills |  |  |  | Today’s temperature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Shortness of Breath |  |  |  |  |
| Chest Pain |  |  |  | Blood Pressure\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ |
| Hemoptysis |  |  |  |  |
| Loss of Appetite |  |  |  |  |
| Night Sweats |  |  |  |  |
| Fatigue |  |  |  |  |
| Swelling of Lymph Node(s) |  |  |  |  |
| Nausea/Vomiting |  |  |  |  |
| Pregnancy |  |  |  |  |
| Yellow skin and/or eyes |  |  |  |  |
| Rash/Itching |  |  |  |  |
| Abdominal Tenderness |  |  |  |  |
| Numbness/tingling/burning of extremities |  |  |  |  |
| Abnormal color of stool or urine |  |  |  |  |

Other Signs and Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **TB MEDICATIONS** | **START DATE** | **DOSAGE/SCHEDULE** | **STOP DATE** | **PRESCRIBING PROVIDER** |
| **RIF** |  |  |  |  |
| **INH** |  |  |  |  |
| **PZA** |  |  |  |  |
| **EMB** |  |  |  |  |
| **B6** |  |  |  |  |
| **Multivitamin** |  |  |  |  |
|  |  |  |  |  |
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| **INTERVAL MEDICAL/SOCIAL HISTORY** |
| New Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ New Medical History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Smoking: ⃞ Yes ⃞ No \_\_\_\_\_\_packs/day Smoking Cessation Education: : ⃞ Yes ⃞ No Alcohol use since last visit: ⃞ Yes ⃞ No  HIV Test previously completed : ⃞ Yes ⃞ No When:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where: ⃞ TB Clinic ⃞ PCP ⃞ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  HIV test provided today: ⃞ Yes ⃞ Patient declined ⃞ Deferred HIV Education Provided ⃞ Yes ⃞ No  HIV Test Results: ⃞ **+** ⃞ **-** If positive, CD4 count: **\_\_\_\_\_\_** and ⃞ Referral to WINGS Clinic |

Signature of Person Taking History:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **LABEL** |

**+ = If History is Positive - = If History is Negative**

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| **PHYSICAL EXAM** | **NL** | **ABNORMAL** |  | **NL** | **ABNORMAL** |
| Constitutional |  |  | Lymphatic |  |  |
| HEENT |  |  | Skin |  |  |
| Respiratory |  |  | Neurologic |  |  |
| Cardiovascular |  |  | Psychiatric |  |  |
| Gastrointestinal |  |  | Musculoskeletal |  |  |

Other Physical Exam Findings:

**Chest X-Ray Results**  Date Taken:

Reading:  Normal  Abnormal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Laboratory Results Other Laboratory Results:**

**Sputum Results**: Date Obtained: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Smear Result: **+ −**

Date Obtained: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Smear Result: **+ −**

Date Obtained: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Smear Result: **+ −**

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| **TB Classification** TB suspect  0 No TB exposure, not infected I TB exposure, no evidence of infection  II Latent TB III TB, clinically active  IV TB, Clinically inactive  **Site of infection**: Pulmonary Cavity Non Cavity Other |
| Plan Isolation Hotel Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Return to work/school \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sputum X \_\_\_\_\_\_\_\_\_ Labs/Imaging:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CMP/Uric Acid CBC HIV    **Contact Investigation**   Initiated Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Completed Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Contact Roster and Summary Sheet sent to KY TB Program Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Follow-up Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Provider’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_