PEDIATRIC ASSOCIATES INC., OF BROCKTON

PATIENT NAME:________________________________DOB:__________DATE:__________

INFANTS, CHILDREN and ADOLESCENTS at HIGH RISK FOR TUBERCULOSIS INFECTIONS

1. Has your child been exposed to adults or children with active tuberculosis infection?
   Yes________No_________

2. Have you come from / spent time in Asia, Africa, Central America, South America, Eastern Europe, or the Middle East?
   Yes________No_________

3. Do you have, or are you exposed to patients who have HIV infection?
   Yes________No_________

4. Do you have an immunosuppressive condition, such as leukemia or malignancies, or are you on chronic steroid therapy?
   Yes________No_________

5. Do you have diabetes mellitus, chronic renal failure or malnutrition?
   Yes________No_________

6. Have you recently been exposed to adults or adolescents who are in a penal institution, or lock up?
   Yes________No_________

7. Were you exposed to homeless people, users of intravenous or street drugs, poor or medically indigent city dwellers, residents of nursing homes, or migrant workers?
   Yes________No_________

8. Do you employ a nanny or other person to regularly care for your children?
   Yes________No_________

   Do you know the tuberculosis skin test status of this individual?
   Yes________No_________

<u>IF YOU OR YOUR CHILD IS EXPOSED TO SOMEONE WITH TUBERCULOSIS OR A POSITIVE SKIN TEST, PLEASE NOTIFY YOUR PHYSICIAN AT PEDIATRIC ASSOCIATES IMMEDIATELY.</u>

PARENT SIGNATURE:____________________________________DATE: ________________

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