HEALTHLINE
MEDICAL GROUP

TUBERCULOSIS FORM

Please Answer Questionnaire:

1. Have you ever had a positive reaction to T.B. skin test? YES__ NO__
2. Have you ever received a BCG vaccination? YES__ NO__
3. Are you pregnant? YES___ NO___

Por favor conteste las preguntas:

1. Alguna vez a tenido la vacuna BCG? SI__NO__
2. Alguna vez a tenido una reaccion positiva al examen de tuberculosis? SI__NO__
3. Esta embarazada? SI___ NO___

Please Print:

PATIENT NAME____

I acknowledge that the above information is true and correct to the best of my knowledge. (Segun mi conocimiento reconozco que la informacion dada es cierta y precisa).

_______________________________________ _______________________
Signature Date

MANTOUX ADMINSTERED ON: ____________________________________

BY: ____MA

EXPIRES:_______________ LOT #: ______________________

SITE: R ____ L ____ FOREARM

MATOUX READ ON: _______________________________________

BY: ____MA

RESULTS: POSITIVE: __________mm NEGATIVE:__________mm

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