

MEDICAL RECORD -- SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of the Surgeon General.

REPORT TITLE <p style="text-align: center;">TUBERCULOSIS SURVEILLANCE</p>	OTSG APPROVED (Date)
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1. Source and reason for referral	
PART I - SUBJECTIVE DATA	
2. Age	3. Sex <input type="checkbox"/> M <input type="checkbox"/> F
4. Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	5. Status <input type="checkbox"/> Active duty <input type="checkbox"/> Dep <input type="checkbox"/> Other
6. Place of birth	
7. How much pain is the patient current experiencing? 0 1 2 3 4 5 6 7 8 9 10	
8. Current prescription medications, over-the-counter medications, and herbals <input type="checkbox"/> Dilantin <input type="checkbox"/> Steroids <input type="checkbox"/> Others:	
9. Drug allergies	
10. Alcohol consumption	11. Tobacco consumption
12. Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> N/A (Male)	13. Method of contraception <input type="checkbox"/> NA (Male)
14. Previous history of tuberculosis or anti-tuberculosis drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," explain.)	
15. Where did the patient come in contact with an active TB case? <input type="checkbox"/> Household <input type="checkbox"/> Work <input type="checkbox"/> Other: <input type="checkbox"/> Unknown	
16a. What are the patient's symptoms? (Select all that apply and explain them in item 16b.) <input type="checkbox"/> Cough <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Unexplained fever <input type="checkbox"/> Anorexia <input type="checkbox"/> Weight loss <input type="checkbox"/> Night sweats <input type="checkbox"/> Fatigue	
16b. Explain all symptoms selected from the list in item 15a.	
17a. What are the patient's present or current medical conditions (Select all that apply and explain them in item 17b.) <input type="checkbox"/> Diabetes <input type="checkbox"/> Alcoholism <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Silicosis <input type="checkbox"/> Gastrectomy <input type="checkbox"/> Use of steroids or immunosuppressives <input type="checkbox"/> Renal disease <input type="checkbox"/> Cancer <input type="checkbox"/> Leukemia <input type="checkbox"/> Hodgkin's Disease <input type="checkbox"/> Human immunodeficiency virus (HIV)	
17b. Explain all present or current medical conditions selected from the list in item 16a.	
18. Does the patient now have, or has the patient ever had, hepatic disease? (If "Yes," please explain.) <input type="checkbox"/> Yes <input type="checkbox"/> No	

(Continue on reverse)

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
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PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)	<input type="checkbox"/> HISTORY/PHYSICAL <input type="checkbox"/> FLOW CHART <input type="checkbox"/> OTHER EXAMINATION OR EVALUATION <input type="checkbox"/> OTHER (Specify) <input type="checkbox"/> DIAGNOSTIC STUDIES <input type="checkbox"/> TREATMENT
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19. List all overseas assignments the patient has had

20. Does the patient desire INH chemoprophylaxis? Yes No

PART II - OBJECTIVE DATA

21. BCG vaccination
 No Yes Date: _____

22. Last negative TB skin test
Date: _____ Type: _____ Unknown

23. Recent PPD results
mm Date given: _____ Dateread: _____

24. Last chest x-ray
Date: _____ Results: _____

PART III - ACTION

25. LFTs

a. SGOT	b. SGPT	c. ALK-PHOS	d. LDH	e. Total BILI	f. Date done
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26. Other lab work ordered

27. Chest x-ray?
 Yes No Date: _____ Results: _____

28. Contact(s) to be skin tested?
 Yes No N/A

29. Education (*Select all that apply.*)

- Implications of a positive TB skin test.
- Symptoms of active TB and mode of transmission.
- Contraindications of further tuberculin skin test.
- Tuberculosis chemoprophylaxis and possible side effects.
- Patient given education material about tuberculosis.
- Patient advised to have family members tested.

PART IV - ASSESSMENT

30. Does the patient have a knowledge deficit regarding TB?
 Yes No

31. The patient is categorized as a/an
 Reactor Converter Case contact Other:

32. Does the patient have any special religious or cultural needs? (*If "Yes," explain.*)
 Yes No

33. Patient meets criteria for INH chemoprophylaxis (*If "No," explain.*)
 Yes No

PART V - PLAN

34. INH chemoprophylaxis

If the response to item 33, Part IV, is --

"Yes," refer the patient to a health care provider for further evaluation. Date of appointment: _____

"No," instruct the patient to seek medical attention if symptoms of active TB occur, and forward the patient's medical record to the Preventive Medicine Physician for further review.

35. Further TB testing
 No further follow up is needed No further TB testing is needed Continue TB skin testing with PPD's

36. Physician's evaluation:
