PATIENT PPD REPORT

Name: _____ Date: _____

DOB: _____ Allergies: _____

Tuberculosis Screening:

Have you ever had a positive PPD?	☐ YES ☐ NO
Have you ever taken medication for treatment of a positive PPD?	☐ YES ☐ NO
Has anyone living with you ever had TB or been treated for a positive PPD?	☐ YES ☐ NO
Have you ever had an allergic reaction to PPD?	☐ YES ☐ NO
Are you pregnant?	☐ YES ☐ NO

Do you or anyone you have contact with have any of the following symptoms?

☐ YES ☐ NO A cough lasting more than 2 weeks	☐ YES ☐ NO Loss of appetite
☐ YES ☐ NO Chest pain	☐ YES ☐ NO Fever & chills
☐ YES ☐ NO Coughing up blood or phlegm	☐ YES ☐ NO Night sweats
☐ YES ☐ NO Unusual weakness or fatigue	☐ YES ☐ NO Unexpected weight loss
☐ YES ☐ NO Shortness of breath	

PPD Test LOT #: _____ Expiration: _____ Administered on: _____ BY _____ *[Date] [Nurse]* Anatomical Location: _____ Read on: _____ BY _____ *[Date] [Nurse]* Results: ☐ Positive _____mm ☐ Negative	PPD Test LOT #: _____ Expiration: _____ Administered on: _____ BY _____ *[Date] [Nurse]* Anatomical Location: _____ Read on: _____ BY _____ *[Date] [Nurse]* Results: ☐ Positive _____mm ☐ Negative

_____ _____

RN Signature *Date*