Appendix 1. Assessment History Form

(Completed by _____)

I. Demographics

Date (dd/mm/yy): _____ Age (yrs): _____ Wt(kg): _____

Current Address: _____ Postal Code: _____

Previous Address (If <6 mo. at current address): _____

Referring Physician: _____

Family Physician (if different from referring physician): _____

Emergency Contact Name and Phone No: _____

Population Group: Status Indian ☐ Non-status Indian ☐ Foreign-born ☐

Métis ☐ Inuit ☐ Cdn-born non –aboriginal ☐

If Aboriginal: On-Reserve ☐ Off-reserve ☐

If Foreign-born: Country of birth: _____

If Foreign-born: Date of Arrival (dd/mm/yy): _____

Travel history within past 24 mos: Country (s) and length of stay: _____

_____

Homeless within past 12 mos: No ☐ Yes ☐ Incarcerated in past 24 mos: No ☐ Yes ☐

Work History/ Occupation: _____

II. TB History

No	Yes	Unknown	
☐	☐	☐	TB Contact /Exposure; If so when: _____
☐	☐	☐	Past History TB; Year: _____
☐	☐	☐	Past Treatment TB Disease: _____
☐	☐	☐	BCG Vaccination: _____
☐	☐	☐	Previous Mantoux: Size _____ mm. Date: _____

III. Health History

Date of last CXR: _____

Current Medications: _____

Allergies: _____

Hospitalization(s) within past 12 mos: _____

LMP:_____ Recent live vaccine or viral Infection No ☐ Yes ☐

High or increased risk medical condition, etc.

No	Yes	
☐	☐	HIV /AIDS _____
☐	☐	Immuno-suppressant drugs (including corticosteroids/ TNF inhibitors) _____
		_____
☐	☐	Dialysis-dependent renal failure _____
☐	☐	Carcinoma of the head and neck _____
☐	☐	Diabetes (Specify if IDDM or NIDDM)_____
☐	☐	Recent (within the past yr.) Alcohol / Substance Abuse (specify) _____
☐	☐	Current Smoker (Pack / Day) _____
☐	☐	Hx of liver disease _____
☐	☐	Were antibiotics prescribed for a respiratory illness during the past 6 months?

If yes: Once ☐ Twice ☐ Three times ☐

IV. <u>Current Symptoms and Their Duration</u>

Symptom /Duration			Symptom /Duration		
No	Yes		No	Yes	
☐	☐	Cough _____	☐	☐	Dysuria_____
☐	☐	Sputum production _____	☐	☐	Nocturia _____
☐	☐	Hemoptysis _____	☐	☐	Headache _____
☐	☐	Chest Pain _____	☐	☐	Lymph Node Swelling _____
☐	☐	Dyspnea RR/Sa02: _____	☐	☐	Bone/Joint Problems _____
☐	☐	Fever _____	☐	☐	Nausea _____
☐	☐	Night Sweats _____	☐	☐	Vomiting _____
☐	☐	Weight Loss _____	☐	☐	Diarrhea _____
☐	☐	Fatigue _____	☐	☐	Other GI Problems _____

V. <u>If Client is a Presumptive or Suspect Active PTB Case</u>

No	Yes	
☐	☐	If productive cough, 3 spontaneous sputa for AFB smear & smear/culture
☐	☐	If dry cough or no cough, 2 induced sputa or 1 bronch wash for AFB smear/culture
☐	☐	TST / IGRA