Londonderry Pediatrics
Tuberculosis Risk Assessment

Patient Name:_____ Date of Birth:_____

Today's Date_____

Please read the questions and circle the answer that applies to your child.

1) Are there any household members who have recently been treated for TB?

   YES NO

2) Are you aware of any cases of TB in your neighborhood?

   YES NO

3) Does your child have a problem with his or her immune system?

   YES NO

4) Has your child ever lived in a foreign country?

   YES NO

5) If you answered YES to question #4, has your child ever received BCG vaccine for TB?

   YES NO

_____ _____

Name of parent/guardian Relationship

Please bring the completed form to your child's well visit. Thank you.