



## Tuberculosis / PPD Skin Test

By signing this form you are agreeing to receive the PPD (purified protein derivative) skin test.  
This test is used to aid in identifying either TB (Tuberculosis) or the exposure to TB.

Please read the following questions thoroughly and answer to the best of your knowledge.

**Yes    No**

1. Have you ever had a BCG Vaccine for TB?
2. Have you had a persistent cough for more than 3 weeks?
3. Have you ever had or do you currently have any of the following symptoms:  
(Night Sweats, Unexplained Weight Loss, Unexplained Fever, Bloody Sputum)
4. Have you ever had TB or had a positive TB skin test?
5. Have you ever been exposed to TB?
6. Have you been prescribed daily steroids in the last month?
7. Have you had any vaccine in the last month?

**DO NOT SCRATCH OR COVER TEST SITE!!!**

**PLEASE RETURN TO CLINIC IN 48 TO 72 HOURS FOR READING.**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_-\_\_\_\_-\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ Employer \_\_\_\_\_

Patient signature \_\_\_\_\_ Date: \_\_\_\_-\_\_\_\_-\_\_\_\_

**The following is for nurse use only.**

Date and Time Test Given: \_\_\_\_\_ AM / PM    Site: R / L Forearm ID  
Lot Number \_\_\_\_\_ Expiration Date \_\_\_\_\_ Nurse Initials \_\_\_\_\_

Date and Time Test is being read \_\_\_\_\_ AM / PM    Nurse Initials \_\_\_\_\_

Results ----     Negative     Positive    Results in mm. of induration: \_\_\_\_\_ mm (*If + reaction*)

