



TB Form H: State of Hawai'i TB Symptom Screen

Hawai'i State Department of Health
Tuberculosis Control Program

1. Symptoms Screen

- **If any symptoms are present, further TB evaluation with risk factor screening and/or TB testing (TST / IGRA / chest X-ray) is required for TB clearance.**
- **Form H is NOT a TB clearance. Please complete Form F to issue a TB clearance.**

<p>1. How long have you been coughing in the past 12 months?</p> <p>a. I have been coughing: <input type="checkbox"/> for 3 weeks (or more) duration; <input type="checkbox"/> for shorter than 3 weeks duration</p> <p>b. (If coughing for more than three weeks), I've been coughing :</p> <p style="margin-left: 20px;"><input type="checkbox"/> up to 3 months; <input type="checkbox"/> up to 6 months; <input type="checkbox"/> longer than 6 months;</p> <p>c. <input type="checkbox"/> In the last year, I have not had a cough for longer than 3 weeks duration</p>		
<p>2. I have been coughing up blood:</p> <p>a. For the past: _____ days / weeks/ months</p> <p style="margin-left: 20px;"><input type="checkbox"/> daily <input type="checkbox"/> frequently <input type="checkbox"/> occasionally</p> <p>b. <input type="checkbox"/> Never</p>		
<p>3. In the past year, I: <input type="checkbox"/> have had temperatures greater than 100 ° F; and these were not associated with a cold, or the flu, or another known infection.</p> <p>In the past year, I: <input type="checkbox"/> have had temperatures greater than 100° F; but these were associated with a cold, or the flu, or other infection.</p> <p>In the past year, I: <input type="checkbox"/> have not had temperatures regularly above 100 °F.</p>		
<p>4. In the past 12 months, I have experienced night sweats:</p> <p style="margin-left: 20px;"><input type="checkbox"/> Frequently <input type="checkbox"/> Occasionally <input type="checkbox"/> Never</p>		
<p>5. In the past year: I have been trying to lose weight and have lost _____ lbs / kgs.</p> <p>In the past year, I have not been trying to lose weight, but have lost / gained _____ lbs / kgs.</p> <p><input type="checkbox"/> In the past year, my weight has remained stable.</p>		
<p>6. <input type="checkbox"/> In the past year, I have felt fatigued but recover with restful sleep.</p> <p style="margin-left: 20px;"><input type="checkbox"/> In the past year, I have felt easily fatigued and do not feel recovered even with sleep.</p> <p style="margin-left: 20px;"><input type="checkbox"/> In the past year, I rarely feel fatigued.</p>		

<p>Medical Staff reviewing symptoms screen:</p> <p>Assessment Date:</p>	<p>Client/Patient's Name and DOB:</p> <p>Name and Relationship of Person Providing Information (if not the above-named person):</p>
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