



ANNUAL TB AND CHOLESTEROL SCREENING QUESTIONNAIRE

FAMILY NAME: _____ **DATE:** _____

TUBERCULOSIS

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| 1. Is there any suspicion that your child(ren) has/have been exposed to an individual who may have TB? | YES | NO |
| 2. Has/have your child(ren) emigrated from Asia, the Middle East, Africa or Latin America? | YES | NO |
| 3. Has/have your child(ren) traveled to or had contact with indigenous people from Asia, the Middle East, Africa or Latin America? | YES | NO |
| 4. Does/do your child(ren) have HIV? | YES | NO |
| 5. Has/have your child(ren) been incarcerated? | YES | NO |
| 6. Has/have your child(ren) been exposed to HIV infected people, homeless people, residents of nursing homes, institutionalized adolescents or adults, users of illicit drugs, incarcerated adolescents or adults, or migrant farm workers? | YES | NO |
| 7. Does/do your child(ren) suffer from diabetes mellitus, chronic renal failure, malnutrition or congenital or acquired immune deficiencies? | YES | NO |

CHOLESTEROL

- | | | |
|---|-----|----|
| 1. Does/do your child(ren) have a parent or grandparent who at less than 55 years of age underwent coronary catheterization or has atherosclerosis, had a heart attack, a stroke or sudden cardiac death? | YES | NO |
| 2. Does/do your child(ren) have a parent with a cholesterol greater than 240mg/dl? | YES | NO |
| 3. Does/do your child(ren) smoke, consume excessive amounts of saturated fats and cholesterol or is overweight? | YES | NO |