

TUBERCULOSIS

BCG Vaccination History

Name _____

Signature _____

Address _____

Contact Number _____

Date of Birth _____

Sex _____

GMC Number _____

1. Have you had a TB vaccination (BCG)?

Yes / No / Unsure

If 'Yes', date of vaccination (approx)

BCG Scar viewed by

Name _____

(Occupational Health Nurse or Dept)

Position _____

Must be verified by Department stamp

Organization _____

Contact Number _____

Details of Occupational Health Qualifications _____

Signature _____

2. Have you had a Mantoux test?

Yes / No / Unsure

If 'Yes', date of test (approx)

3. What was the result of your last Mantoux test?

No reaction / weak positive / positive / strongly positive / can't remember

If it was '*strongly positive*'-

Did you have a chest x-ray?

Yes / No

If 'Yes', was it normal?

Yes / No

Did you see a Doctor who specializes in infectious diseases?

Yes / No

Have you been offered medication?

Yes / No

If 'Yes', did you complete a course of medication?

Yes / No

