CITY OF LONG BEACH
DEPARTMENT OF HEALTH AND HUMAN SERVICES
TB CONTROL PROGRAM
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CONFIDENTIAL TUBERCULOSIS SUSPECT CASE REPORT

Patient_____
Address_____
_____
Phone: ( )_____
Birthdate:____/____/____ Sex: ☐ Male ☐ Female
Social Security Number:_____
** If patient under 18, (PARENT NAME/DOB)
_____

EMPLOYER/SCHOOL:_____
OCCUPATION:_____

☐ White ☐ Non-Hispanic ☐ Black ☐ AM Ind/Eskimo
☐ Hispanic ☐ Asian/Pac. Is (Specify)_____
Country of Origin:_____ Date of Entry: _____
Primary Language Spoken: _____
Emergency Contact Person: (Name/Relationship/Ph#):
_____

Reported By: _____
Phone: ( )_____ FAX:( )_____
Hospital/Clinic where diagnosed_____
Medical Record#_____
Pt. Currently hospitalized? ☐ Yes ☐ No Adm. Date_____
Treating Physician:_____
Address_____
_____
Phone: ( )_____

Referred for F/U_____MD
Address_____
_____
Phone: ( )_____

Will MD be continuing care? ☐ Yes ☐ No

Date of Diagnosis:____/____/____

SKIN TEST Date:____/____/____
Result_____mm
☐ Not done ☐ Unknown

If Pulmonary, check symptoms.
☐ Cough ☐ Night sweats
☐ Sputum production ☐ Hemoptysis
☐ Weight loss (No. of lbs)

Pulmonary TB ☐ Extra Pulmonary ☐ (Site)_____

CHEST X-RAY Date:____/____/____ ☐ Cavitary ☐ Non-Cavitary
Impression_____
_____
Past history of TB Treatment ☐ No ☐ Yes
If yes, where, when treated? _____
_____

Allergies:_____

If asymptomatic, reason for evaluation_____
_____
Other medical conditions relevant to diagnosis_____
_____
Psychosoical History _____
_____

HIV STATUS DATE____/____/____
☐ Positive ☐ Negative ☐ Unknown
☐ Not done ☐ Refused ☐ Pending

BACTERIOLOGY
Pathology Report:_____
Lab Name and Account #:_____

Weight_____ Height_____

Spec. No.	Spec. Collection Date	Spec. Type	Smear AFB +/-	Culture M. TB +/-

Medications	Dose	Start Date

Additional Comments:_____
_____

Date Reported:____/____/____ Recorded By:_____