Centre for Tuberculosis Prevention Questionnaire

LAST NAME: **Date:**

FIRST NAME: **Home Address:**

DATE OF BIRTH:

- **Have you had one or several of the following symptoms for more than 3 weeks? If yes, please circle the symptom/s in the following list:**

Chronic cough

Fever

Loss of appetite

Coughing up blood

Night sweats

Fatigue

Weight loss

Chest pains

- **Have you already had Tuberculosis?**

  YES☐ NO☐ I don't know☐

  If yes, in which country? ……..

  If yes, when? ……

  If yes, what medication did you take? ……..
  ……..

  How long did the treatment last? ……..

- **Have you ever come into contact with someone with Tuberculosis?**

If yes, when? ……

If yes, whos? (family, friends, neighbours…)?.....

- **Have you been vaccinated for Tuberculosis (BCG)?**

  YES☐ NO☐ I don't know☐

- **What is your home country?** ……

- **How long have you been in France?** ……

- **What was your migratory pathway? Which countries did you cross?**

  ……

- **Have you returned to your home country?**

  YES☐ NO☐ If yes, when? ……

  ……

- **Do you smoke?**

  YES☐ NO☐ If yes, how many cigarettes a day?

  ……

- **Do you have health problems?**

  YES☐ NO☐

  If yes, what health problems?

  ……

  ……

- **Are you currently taking medication?**

  If yes, what medication?

  ……