**Do you have:**

**A history of Tuberculosis? Yes  No  If yes, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Symptoms of tuberculosis?**

Productive cough ( > 3 weeks):  **Yes  No  If yes, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Bloody sputum **Yes  No  If yes, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Night sweats **Yes  No ** Fatigue **Yes  No **

Malaise **Yes  No ** Fever **Yes  No **

Unexplained weight loss **Yes  No **

**Flu & Other Aerosol transmissible diseases, including pertussis, measles, mumps, rubella, chicken pox, meningitis:**

**Do you have: How long? Explain:**

Fever? **Yes  No  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Body aches? **Yes  No  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Runny nose? **Yes  No  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Sore throat? **Yes  No  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Headache? **Yes  No  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Nausea? **Yes  No  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Vomiting or diarrhea? **Yes  No  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Fever and respiratory symptoms? **Yes  No  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Severe coughing spasms? **Yes  No  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Painful, swollen glands? **Yes  No  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Skin rash, blisters? **Yes  No  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Stiff neck, mental changes? **Yes  No  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dental facilities must pre-screen patients for aerosol transmissible diseases. Dental procedures are not performed on patients suspected or identified as having aerosol transmissible diseases.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Chronic Respiratory Diseases (NOT ATD’s, and not considered infectious) do not disqualify a patient from treatment: Do you have:**

Asthma? **Yes  No **

Allergies? **Yes  No **

Chronic upper airway cough syndrome “postnasal drip”? **Yes  No **

Gastroesophageal reflux disease (GERD)? **Yes  No **

Chronic obstructive pulmonary disease (COPD)? **Yes  No **

Emphysema? **Yes  No **

Bronchitis? **Yes  No **

Dry cough from ACE inhibitors? **Yes  No **

Dental offices are NOT required to use this to screen patients for aerosol-transmissible diseases. This form is provided as an example of an efficient method of screening patients.