

## MONTHLY EVALUATION FOR PATIENTS RECEIVING TREATMENT FOR LATENT TUBERCULOSIS INFECTION (LTBI)

FOR THE PATIENT *(Check the correct response)*

1. What medications have you been taking for Latent Tuberculosis Infection and how long have you taken the medication?

1a. Isoniazid	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Number of months:
1b. Rifampin	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Number of months:
1c. Rifabutin	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Number of months:
1d. Pyrazinamide	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Number of months:
1e. Ethambutol	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Number of months:
1f. Pyridoxine (Vitamin B <sub>6</sub> )	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Number of months:
1g. Other medication <i>(Name of medication and number of months taken)</i>			

2. How many days in the past month *(if any)* did you miss taking your medication?

3a. Are you taking any other medications?  YES  NO

3b. If yes, what medications are you taking?

4a. Do you drink alcoholic beverages?  YES  NO

4b. If yes, explain alcohol use.

5a. Do you have any allergies?  YES  NO

5b. If yes, what allergies do you have?

6a. Do you use tobacco?  YES  NO

6b. If yes, explain.

SINCE MY **LAST EVALUATION** I HAVE EXPERIENCED *(Check the correct response)*

7. Persistent <i>(chronic)</i> cough	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8. Coughing up blood	<input type="checkbox"/> YES	<input type="checkbox"/> NO
9. Any unexplained fever	<input type="checkbox"/> YES	<input type="checkbox"/> NO
10. Unexplained weight loss	<input type="checkbox"/> YES	<input type="checkbox"/> NO
11. Night sweats	<input type="checkbox"/> YES	<input type="checkbox"/> NO
12. Nausea, vomiting, diarrhea	<input type="checkbox"/> YES	<input type="checkbox"/> NO
13. Dark colored urine	<input type="checkbox"/> YES	<input type="checkbox"/> NO
14. Unexplained muscle or joint pain	<input type="checkbox"/> YES	<input type="checkbox"/> NO
15. Feeling run down or excessively tired	<input type="checkbox"/> YES	<input type="checkbox"/> NO
16. Burning or tingling in my hands or feet	<input type="checkbox"/> YES	<input type="checkbox"/> NO
17. Bleeding that did not stop as usual	<input type="checkbox"/> YES	<input type="checkbox"/> NO
18. Problems with my medications	<input type="checkbox"/> YES	<input type="checkbox"/> NO

FEMALES ONLY

19. Are you or could you be pregnant?  YES  NO  NOT SURE

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: <i>(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)</i>	HOSPITAL OR MEDICAL FACILITY	
	STATUS	RECORDS MAINTAINED AT
	DEPARTMENT / SERVICE	
	SPONSOR'S NAME	SSN
RELATIONSHIP TO SPONSOR		