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	☐ YES	☐ NO	Number of months:
1b. Rifampin	☐ YES	☐ NO	Number of months:
1c. Rifabutin	☐ YES	☐ NO	Number of months:
1d. Pyrazinamide	☐ YES	☐ NO	Number of months:
1e. Ethambutol	☐ YES	☐ NO	Number of months:
1f. Pyridozine (Vitamin B_6)	☐ YES	☐ NO	Number of months:

1g. Other medication *(Name of medication and number of months taken)*

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 *(chronic)* cough	☐ YES	☐ NO
8. Coughing up blood	☐ YES	☐ NO
9. Any unexplained fever	☐ YES	☐ NO
10. Unexplained weight loss	☐ YES	☐ NO
11. Night sweats	☐ YES	☐ NO
12. Nausea, vomiting, diarrhea	☐ YES	☐ NO
13. Dark colored urine	☐ YES	☐ NO
14. Unexplained muscle or joint pain	☐ YES	☐ NO
15. Feeling run down or excessively tired	☐ YES	☐ NO
16. Burning or tingling in my hands or feet	☐ YES	☐ NO
17. Bleeding that did not stop as usual	☐ YES	☐ NO
18. Problems with my medications	☐ YES	☐ 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: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	