The Center for Reproductive Health.

2410 Patterson Street Suite 401 ♦ Nashville ♦ TN ♦ 37203 ♦Voice: (615) 321-8899 ♦ FAX: (615) 321-8877

PATIENT NAME: ____

Additional Patient History

Please answer the following questions and return to the receptionist at your initial appointment.

1. Have you had or do you have a prolonged cough greater than two weeks?
2. Have you had or do you have a cough with production of sputum or blood?
3. Are you experiencing fatigue, loss of appetite, weight loss, or fever? If yes, please specify.
4. Have you ever been diagnosed or treated for Tuberculosis (TB)?
   Have any of your friends or family been diagnosed or treated?
5. Have you ever had a positive result to Tuberculosis (TB) skin testing?

Thank you for taking the time to answer these important medical questions.

______________________________________ ______________________

Signature Date