

Last Name	First Name	MI
Patient Number		
Date of Birth (MM/DD/YYYY)		
	Month	Day
Year		
Race		
Ethnicity: Hispanic or Latino Origin? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male		
County of Residence		

## TUBERCULOSIS FLOW SHEET

**Allergies**

Medication	INH	RIF	PZA	EMB		
Date Started						
Date Stopped						

**Check all that apply:**

- HIV testing / Date \_\_\_/\_\_\_/\_\_\_\_\_
- Positive  Negative
- No HIV test taken
- TB card given and discharge
- Drug information sheet(s) given
- Discussed potential side effects & action to take
- Release of information signed
- Declined treatment
- TB treatment agreement signed

<b>Visit Date</b>									
Weight									
Date of Last Menstrual Period									
Sputums Collected									
Blood Chemistry Drawn									
<b>Medications:</b>									
Birth Control (specify method)									
Hormone Replacement Therapy									
Insulin/Oral Hypoglycemic Agents									
Steroids									
Anticonvulsants									
Methadone									
Antibiotics									
Anticoagulants									
Statin drugs									
Heart Medication									
HIV Medication									
Immunosuppressive drugs/Anti-TNF Drugs									
Other (specify)									

**\*Notes**

SIGNATURE (each visit)



Patient Name, #, or DOB  
or  
Attach Patient Label Here

## Monitoring for Drug Reactions

<b>Visit Date</b>										
<b>GENERAL SIDE EFFECTS – ALL MEDS</b>										
Loss of Appetite										
Nausea/Vomiting/Abdominal Pain										
Unusual Fatigue/Weakness										
Jaundice/Brownish Urine										
Unexplained Fever/Chills										
Unexplained Headaches										
Mental Changes										
Muscle or Joint Pain										
Flushing										
Rash/Itching										
Diarrhea										
<b>ISONIAZID</b>										
Numbness/Tingling of the Extremities										
<b>RIFAMPIN/RIFABUTIN/RIFAPENTINE</b>										
Bruising/Bleeding										
Flu-like Symptoms										
Symptoms of low blood pressure (dizziness or fainting)										
<b>ETHAMBUTOL</b>										
Red/Green Color Discrimination										
Visual Acuity R										
Visual Acuity L										
Visual Acuity Both										
<b>PYRAZINAMIDE</b>										
Increased Sun Sensitivity										
<b>AMINOGLYCOSIDES (SM, KM, ETC)</b>										
Second Line Drugs Require Additional Monitoring										
<b>FLUOROQUINOLONES (LEVO/MOXIFLOXICIN)</b>										
Tendon Pain (especially Achilles tendon)										
Palpitations/abnormal heartbeat										
Other (specify)										

**\*Notes**

SIGNATURE (each visit)