

## CLERKING SHEET FOR TB CASE (FIRST REVIEW)

Date: \_\_\_\_\_

Time: \_\_\_\_\_

### 1. HISTORY OF PRESENTING ILLNESS:

a. Main symptoms and duration of illness:

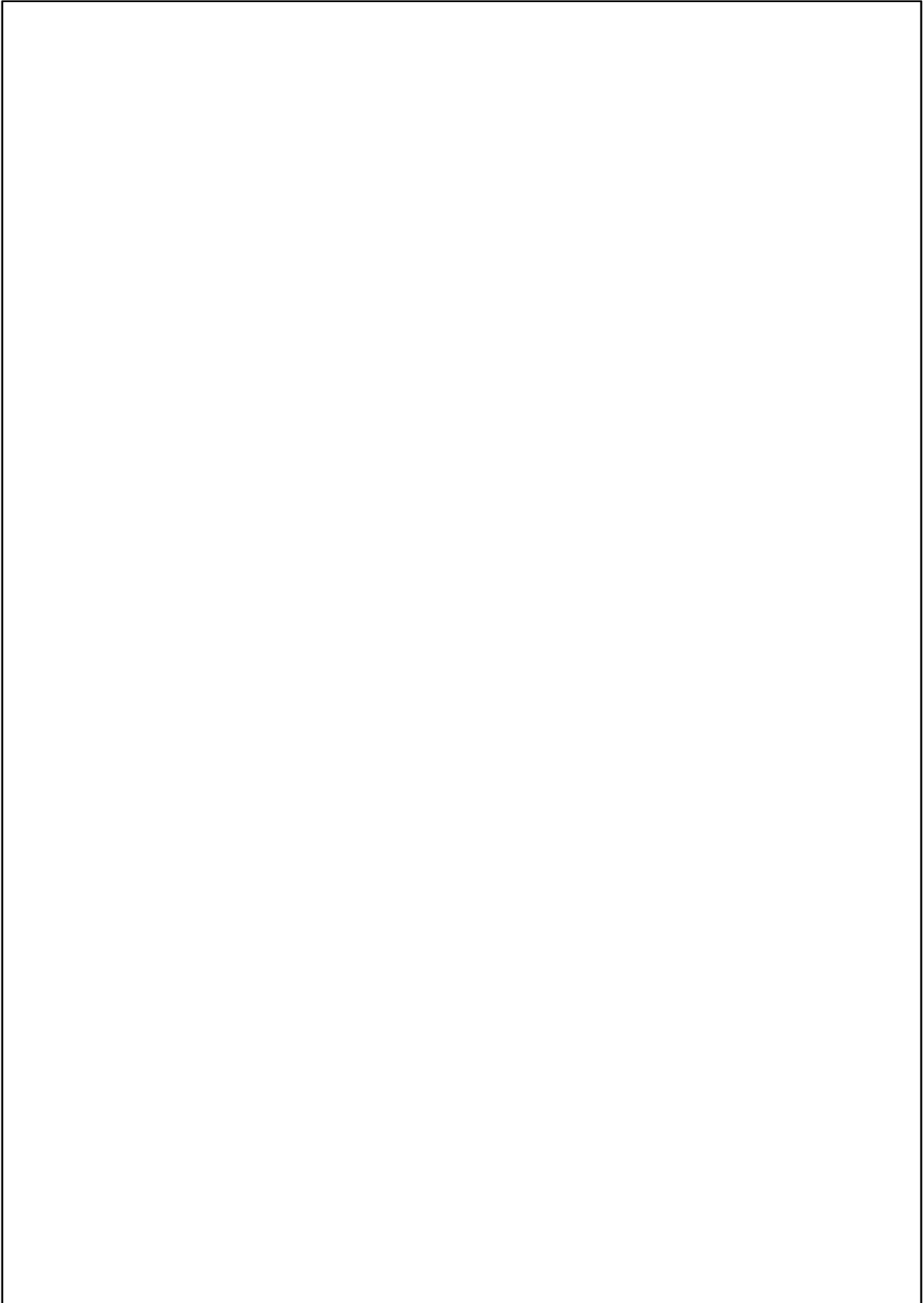
Symptoms	Yes	No	Details
Cough :			Duration :
Productive			
Hemoptysis			
Chest pain:			
Loss of appetite			
Unexplained weight loss			
Fever			
Night sweats			
Other symptoms			

### 2. FAMILY HISTORY

a. contact history

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b. Family tree



**3. PAST MEDICAL/SURGICAL HISTORY:**

	Yes	No	Details
Past Medical History			
Past Surgical History			
History of seeking treatment for symptoms of TB before being diagnosed as TB			

**4. SOCIAL HISTORY:**

	Yes	No	Details
Travelling history			
High risk behaviour			
Alcohol intake			
Smoking history			
Occupation:			

**5. MEDICATION/DRUGS HISTORY:**

Previous treatment:	Side effects:	Allergy history:	Current medication:

**6. CLINICAL EXAMINATION:**

**a. Vital Signs:**

BP:

RR:

PR:

Temperature:

Weight:

Pain Score:

**b. General physical examination:**

Pallor


Cyanosis


Jaundice

Lymphadenopathy

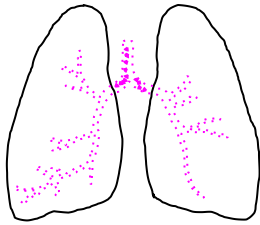
Clubbing

Edema

Nutritional status:

**c. Systemic examination:**

i. Respiratory system:

Inspection	Palpation	Percussion	Auscultation
			

ii. Other Systemic Examination:

CVS:

Per Abdomen:

**7. DIAGNOSIS**

a. Date of diagnosis: \_\_\_\_\_

b. Notification date: \_\_\_\_\_

**c. Mode of diagnosis:**

Clinical diagnosis:	<input type="checkbox"/> Yes/No	Bacteriological diagnosis:	<input type="checkbox"/> Yes/No
<u>Evidence</u> : tick (✓)		<u>Evidence</u> : tick (✓)	
CXR:	<input type="checkbox"/>	Sputum:	<input type="checkbox"/>
CT:	<input type="checkbox"/>	Culture	<input type="checkbox"/>
Others: _____			<input type="checkbox"/>

**d. Classification of tb case:**

Pulmonary TB smear positive	<input type="checkbox"/>	Extra pulmonary TB	<input type="checkbox"/>
Pulmonary TB smear negative	<input type="checkbox"/>	Pulmonary TB with extrapulmonary TB	<input type="checkbox"/>

**e. Type of case:**

New case  relapse  treatment after interruption  treatment after failure

**8. TREATMENT REGIME:**

Date treatment started:

FDC (Forecox/Akurit-4): \_\_\_\_\_ tablets

i/m SM : \_\_\_\_\_ GM

INH : \_\_\_\_\_ mgm

RIF : \_\_\_\_\_ mgm

PZA : \_\_\_\_\_ mgm

ETB : \_\_\_\_\_ mgm

Vit B6 : \_\_\_\_\_ mgm

Place of DOT: \_\_\_\_\_

**Next date for follow up:**

**Doctor's name, sign & stamp:**

**Time & Date:**