SAN ANTONIO METROPOLITAN HEALTH DISTRICT

Tuberculosis Case Report

1. SS No. _____ Race _____ 2. Report Date _____

3. Name _____ 4. D. O. B. _____ Sex _____

5. Address _____ 6. Phone _____

5a. _____ 7. Physician's Name _____
City Co. State Zip

8. Name of Hospital & ID No. _____ 9. Adm. Date _____

10. Diagnosis: ( ) Tbc, Current Disease ( ) Tbc Suspect

( ) Tbc, No Current Disease ( ) Positive Reactor, No Disease

11. Infection Site: ( ) Pulmonary ( ) Extrapulmonary _____
(Please Specify)

12. TB Test Date: _____ _____mm of Induration

(Mantoux) ( ) Not done ( ) Not Read

13. X-ray Date: _____

( ) Normal ( ) Stable ( ) Cavitary

( ) Abnormal ( ) Worse ( ) Non-cavitary

( ) Not done ( ) Unknown ( ) Not stated

14. Bacteriology: ( ) Not done ( ) Pending

Date	Source	Lab No.	Smear Results	Culture Results

15. Treatment: Drug Start Date: _____

Medication	Dosage	Frequency	Medication	Dosage	Frequency

16. Comments: _____

_____

_____

_____

_____
Signature

LTB No. 2 9/85

Exhibit 11