Personal ID number: ..... - ..... (ten digits) Date:.....

Name: ..... **Native language:** .....

Place of work/address .....

Phone number: ..... **Mobile number:** .....

Health declaration regarding tuberculosis in pregnant women (staff and immigrants)

Put an 'X' in the box or boxes that you feel are true about you.

1. Do you have any of the following symptoms?

☐ Persistent cough for more than 6 weeks
☐ Periodic fever
☐ Loss of weight, more than 5 kg in 6 months
☐ None of the above

2. Have you had tuberculosis yourself?

☐ Yes ☐ No ☐ Don't know

3. Has anyone that you live together with or any other close relative (e.g. maternal or paternal grandparents) had tuberculosis or had a regular check for suspected tuberculosis?

☐ Yes ☐ No ☐ Don't know
If yes, who and when: _____

4. Were you born in Sweden?

☐ Yes ☐ No (state which country) _____

If no, how long did you live in your native country? _____

5. Have you lived for three months or longer in a country with a high incidence of tuberculosis (Asia, Africa, South and Central America, and Southern and Eastern Europe)?

☐ Yes ☐ No

If yes, where and for how long?_____

6. Have you been BCG vaccinated (vaccinated against tuberculosis?

☐ Yes ☐ No ☐ Don't know

If yes, do you know where and when? _____