Bilaga 1

Health declaration in regards to tuberculosis

Date: ______________________________

Name: ______________________________ Personal ID/ Date of birth:___________ - _____

1. **Do you have one or more of the following symptoms?** (*Mark all boxes that apply*)

   Cough for more than 2 weeks?
   Fever?
   Involuntary weight loss?
   Night sweat
   No, I have not had any of these symptoms

2. **Have you had tuberculosis yourself?**
   ☐ Yes
   ☐ No
   ☐ Don't know

3. **Do you have any relatives or other close contacts with confirmed or suspected tuberculosis?**
   ☐ Yes **[If yes]**, who and when:____
   ☐ No
   ☐ Don't know

4. **Were you born outside Sweden?**
   ☐ Yes **[If yes]**, in what country and for how long did you live there? ____________________
   ☐ No

5. **Have you stayed for more than 3 months in any country outside Western Europe/North America/Australia?**
   ☐ Yes **[If yes]**, in which country and for how long?___________________________________
   ☐ No

6. **Have you been vaccinated with BCG against tuberculosis?**
   ☐ Yes **[If yes]**, where and when? ____
   ☐ No
   ☐ Don't know

I declare that the information given in the health declaration above is complete and genuine.

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Date	Signature	Printed name