

TUBERCULOSIS SCREENING QUESTIONNAIRE

Employee Name

Date

Positive TB skin test (PPD) Date: _____ Last Chest X-Ray Date: _____

PLEASE INDICATE IF YOU ARE HAVING ANY OF THE FOLLOWING FOR 3-4 WEEKS OR LONGER:

- | | | |
|---|----------|---------|
| 1. Chronic Cough (greater than 3 weeks) | Yes ____ | No ____ |
| 2. Do you cough up blood or have bloody sputum? | Yes ____ | No ____ |
| 3. Have you had unexplained weight loss? | Yes ____ | No ____ |
| 4. Do you have unexplained fever? | Yes ____ | No ____ |
| 5. Do you have unexplained fatigue/tiredness? | Yes ____ | No ____ |
| 6. Do you have recurrent night sweats? | Yes ____ | No ____ |
| 7. Do you have shortness of breath? | Yes ____ | No ____ |

There is no evidence of Pulmonary Tuberculosis or Contagium.

Employee Signature

Date

Physician

Date