U.S. Nursing Tuberculosis Screening
Questionnaire

______________________________ ______________________
Name Date

Positive TB skin test (PPD) Date: ___________________________________

Last Chest X-Ray Date: ____

Please indicate if you are having any of the following problems for three to four weeks or longer:

1. Chronic Cough (greater than 3 weeks) Yes _____ No _____
2. Production of Sputum Yes _____ No _____
3. Blood-Streaked Sputum Yes _____ No _____
4. Unexplained Weight Loss Yes _____ No _____
5. Fever Yes _____ No _____
6. Fatigue/Tiredness Yes _____ No _____
7. Night Sweats Yes _____ No _____
8. Shortness of Breath Yes _____ No _____

______________________ ______________________________
Date Agency Employee Signature