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 Employee Signature