USNURSING CORPORATION

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