TB Screening Questionnaire

Employee Name: ____

This form is completed annually for all field employees

Do you experience any of the following:	Yes	No
• bad cough that lasts longer than 2 weeks	☐	☐
• coughing up sputum (phlegm)	☐	☐
• coughing up blood	☐	☐
• loss of appetite	☐	☐
• weakness/fatigue/tiredness	☐	☐
• night sweats	☐	☐
• unexplained weight loss	☐	☐
• fever	☐	☐
• chills	☐	☐
• chest pain	☐	☐

Have you recently spent time with someone who has infectious tuberculosis? ☐ Yes ☐ No

Foreign-born person from or recent traveler to high-prevalence area ☐ Yes ☐ No

Chest radiographs with fibrotic changes suggesting inactive or past TB ☐ Yes ☐ No

HIV infection ☐ Yes ☐ No

Organ transplant recipient ☐ Yes ☐ No

Resident or employee of high-risk congregate setting (LTCF, Hospital) ☐ Yes ☐ No

Immunosuppression due to medication or Chronic Disease ☐ Yes ☐ No

Any other complaints? ☐ Yes ☐ No If yes, explain: ____________________________

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The above health statements are accurate to the best of my knowledge. I have been in-serviced on the signs and symptoms of tuberculosis and been advised to seek medical care if any of the symptoms develop at any time.

Employee Signature:_____________________________________ Date:_____________

Nurse Reviewer Recommendation

☐ Refer employee TB/LTBI screening before continuing work.

☐ Refer employee for medical evaluation immediately, before continuing work.

☐ No action to be taken at this time.

RN Signature:____ Date:_____________