Hamilton Davis Home Care, Inc.

Tuberculosis Signs & Symptom Checklist

NAME: _____ DATE: _____, 20_____

LAST FOUR OF SOCIAL SECURITY NUMBER: XXX-XX-_____

If any of the following apply, please check the appropriate box:

YES	NO	
☐	☐	Cough, if yes, is it ☐ Productive ☐ Nonproductive
☐	☐	Hemoptysis (spitting up blood)
☐	☐	Chest Pains
☐	☐	Weight Loss
☐	☐	Fever
☐	☐	Weakness
☐	☐	Loss of appetite
☐	☐	Difficulty Breathing
☐	☐	Night Sweats

Comments: _____

_____

_____

RN Name (Please Print): _____

RN Signature: _____

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