TB Screening Questionnaire

Periodic/Post Exposure:
Last Tuberculin SkinTest Negative

_____
Last Name **First Name** **MI** **Date Form Completed: _____/_____/____**

Date of Birth____/____/____

Department: In-Home Care **Job Title:** Home Care Aid **Home Phone**_____

1. Since your last TB skin test, have you worked in a location where patients with TB received care or services?
   [ ] Yes [ ] No [ ] Don't know

2. Since your last TB skin test, have you lived with or had close contact with someone who has TB?
   [ ] Yes [ ] No [ ] Don't know

3. Since your last TB skin test, has your negative test turned to a positive?
   [ ] Yes [ ] No [ ]Don't know

4. Since your last TB skin test, have you had an abnormal Chest x-ray?
   [ ] Yes [ ] No [ ] Don't know

5. Since your last TB skin test, has a health practitioner told you that your immune system isn't working or can't fight infection?
   [ ] Yes [ ] No [ ] Don't know

6. Do you work, volunteer, or live in another facility that provides medical or social services?
   [ ] Yes [ ] No [ ] Don't know

7. Since your last TB skin test, have you traveled outside the U.S.A.?
   [ ] Yes [ ] No [ ] Don't know

8. Since your last TB skin test, have you had any of the following symptoms for more than 3 weeks at a time? (*Please check all that apply*)

   [ ] Persistent coughing [ ] Excessive fatigue [ ] Coughing up blood
   [ ] Hoarseness [ ] Excessive sweating at night [ ] Persistent fever
   [ ] Excessive weight loss [ ] **NONE OF THE ABOVE**

THE ABOVE INFORMATION IS ACCURATE AND CORRECT:

_____
EMPLOYEE SIGNATURE