Annual TB Screening

NAME: _____

Have you any previously known positive reaction or history of tuberculosis? ❒ Yes ❒ No

If yes, the result of at least one **Chest X-Ray** is required on file. Please **submit a copy** of the Chest X-Ray results and complete *Annual TB Questionnaire* form below. If No, complete the Mantoux Testing Record table.

Chest X-ray:

Date:_____ Results: _____

Previous chest X-ray completed and on file? ❒ Yes ❒ No If yes, indicate date:_____

Comments:_____

TB Questionnaire

Please complete this form *annually* if you have tested positive for TB. If you answer "Yes" to any of the questions listed below, please explain under the "Comments" section. *Sign and date the bottom of the page*.

Yes	No	Question	Comments
		Cough or cold that won't go away?	
		Unexplained weight loss?	
		Night sweats?	
		Fever of unknown origin?	
		Shortness of breath?	
		Productive cough?	
		Bloody sputum?	

Mantoux Testing Record

Date Given	*Given By*	*Site*	*Date Read*	*Reaction in mm*	*Read By*

Employee Signature:_____ Date:_____