



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

Employee Signature