



## TB Screening Questionnaire

Employee Name: \_\_\_\_\_

This form is completed annually for those employees who have documentation of a negative TB skin test or chest x-ray following a positive Mantoux screening test, and whose medical evaluation and chest x-ray indicate that no further Mantoux screening is required.

Do you experience any of the following:	Yes	<u>No</u>
• bad cough that lasts longer than 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
• coughing up sputum (phlegm)	<input type="checkbox"/>	<input type="checkbox"/>
• coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>
• loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>
• weakness/fatigue/tiredness	<input type="checkbox"/>	<input type="checkbox"/>
• night sweats	<input type="checkbox"/>	<input type="checkbox"/>
• unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>
• fever	<input type="checkbox"/>	<input type="checkbox"/>
• chills	<input type="checkbox"/>	<input type="checkbox"/>
• chest pain	<input type="checkbox"/>	<input type="checkbox"/>
- Have you recently spent time with someone who has infectious tuberculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
-Foreign-born person from <b>or</b> recent traveler to high-prevalence area	<input type="checkbox"/> Yes	<input type="checkbox"/> No
-Chest radiographs with fibrotic changes suggesting inactive or past TB	<input type="checkbox"/> Yes	<input type="checkbox"/> No
-HIV infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No
-Organ transplant recipient	<input type="checkbox"/> Yes	<input type="checkbox"/> No
-Resident or employee of high-risk congregate setting (LTCH, Hospital)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
-Immunosuppression due to medication or Chronic Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any other complaints? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, explain: _____		

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: \_\_\_\_\_