



Employee Name: _____

Annual Tuberculosis Screening Questionnaire

1. Do you currently have any of the following signs or symptoms?

	<u>YES</u>	<u>NO</u>	<u>COMMENTS</u>
Weakness	_____	_____	_____
Fatigue	_____	_____	_____
Lack of Appetite	_____	_____	_____
Weight Loss	_____	_____	_____
Low Grade Fever	_____	_____	_____
Night Sweats	_____	_____	_____
Flu-Like Symptoms	_____	_____	_____
Chest Pain	_____	_____	_____
Shotness of Breath	_____	_____	_____
Persistent Cough	_____	_____	_____
Blood-Streaked Sputum	_____	_____	_____
Yellow or Dark Sputum	_____	_____	_____

2. Have you been exposed to anyone with the above signs or symptoms or who has had tuberculosis?

Yes No

If I should notice any of the above signs or symptoms, I will notify my Primary Care Provider and my agency immediately.

Employee Signature _____

Date:

Primary Care Provider Signature: _____

Date:

(stamp)