Tuberculosis Symptom Screening Questionnaire

This form is to be used for persons who are required to have TB screening for employment, post-secondary educational institution admission, long term residential care admission, correctional facility intake, or fulfillment of other statute or regulation. *Part A should be completed by the person for whom the TB Skin Test is required. A healthcare professional must evaluate the answers and assign a recommendation from Part B.*

PART A

1. Have you experienced any of the following symptoms in the past year?		
a.) A productive cough for more than 3 weeks?	Yes	No
b.) Hemoptysis (coughing up blood)?	Yes	No
c.) Unexplained weight loss?	Yes	No
d.) Fever, Chills, or night sweats for no known reason?	Yes	No
e.) Persistent shortness of breath?	Yes	No
f.) Unexplained fatigue?	Yes	No
g.) Chest Pain?	Yes	No
2. Have you had contact with anyone with active tuberculosis disease in the past year?	Yes	No
3) Do you have a medical condition, or are you taking medications, which suppress your immune system?	Yes	No

3. Why are you required to have a TB Skin Test?

_____

Please provide details to any question answered "Yes".

I declare that my answers and statements are correctly recorded, complete, and true to the best of my knowledge.

_____ _____ _____

Signature of person required to be tested | Printed Name | Date

PART B

Upon review of the responses to the questionnaire and discussion with the person for whom the tuberculosis evaluation is required, I recommend as follows:

_____There is no indication this person has active tuberculosis at this time.

_____ _____ _____

Healthcare Professional Signature | Printed Name | Date

_____ _____

Agency/Practice Name | Contact Phone

HALLSVILLE
— MEDICAL CLINIC —

First Name:		I II III IV V	Age:
Last Name:		Jr. Sr.	
Mailing Address:		Date of Birth:	
City, State:		Phone:	
Zip:		SSN:	
Sex: M F			
Email Address:			

I authorize the release of my information to the following person: (If none, leave blank.)

Emergency Contact Name:	
Emergency Contact Phone:	
Any Restrictions:	
Relationship:	

For office use only.

Procedure: TB Skin Test

Date Placed: _____ Site: Left / Right Forearm

Lot: _____ Expiration Date: _____

Administered By: _____

Date Read: _____ Induration (in mm): _____

PPD Result: Negative/Positive

Result Read By: _____

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