Employee Tuberculosis Screening Questionnaire

______________________ ____________________________ __________________

Employee's Name Job Title Date

All employees are required to participate in screening for Tuberculosis. All employees must complete the following screening questionnaire if the agency is determined to be low risk per the CDC Guidelines:

Tuberculosis Symptom Review Do you *currently* have symptoms of:	**YES**	**NO**
1. Unusual fatigue for more than two weeks		
2. Weight loss > 10% of body weight. (unrelated to dieting)		
3. Loss of appetite for more than two weeks		
4. Persistent cough longer than a three-week duration.		
5. Blood-streaked sputum		
6. Fever-associated with cough for more than one week		
7. Night sweats		
8. Pain in chest when taking a breath		
9. Have you had or been exposed to TB, or had a positive TB result?		
10. Do you currently have any respiratory problems (asthma, cold, bronchitis, etc.)?		
11. Are you pregnant at this time?		
12. Other unusual symptoms, if yes explain in comments below:		
13. If yes to any of the above, are you currently under a physician's care		
14. Have you traveled or lived outside the U.S.A. in the last two years?		
15. Have you ever had a positive TB test in the past?		
16. Have you been on any chemotherapy, immunotherapy or steroids in the past 6 weeks?		
17. Have you had a live vaccine within the last 6 weeks?		
18.Comments:		

I further certify to the best of my knowledge the above statements are true.

________________________________ ____________

Signature Date