Annual Tuberculosis Risk/Symptom Screening Questionnaire

This form is to be used annually when an employee or child has increased risk or a positive result occur from Tuberculosis screening using either skin testing (PPD) or blood sample (QFT-G or IGRA).

Name_____ **Date**_____

Positive TB skin test (PPD) Date:_____

OR

Positive Quantiferon- Gold (QFT-G) or IGRA date: _____

If either PPD or QFT-G (IGRA) is positive- then:

Last Chest X-Ray Date: _____ **(result must be on file)**

Were you or the child born outside the United States? Yes_____ No_____.
Has there been travel outside the United States or close contact with persons who are native to countries outside of the United States within the past year? Yes____ No____.

If YES, what country/ies_____

Have you had 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 _____**
6.	**Night Sweats**	**Yes ____**	**No _____**
7.	**Shortness of Breath**	**Yes _____**	**No _____**

Date_____ _____
Employee signature

YES NO EVIDENCE OF PULMONARY TUBERCULOSIS OR CONTAGIUM.

Date_____ _____ _____
Health Care Provider (M.D., D.O., N.P.) (print last name)

OECOSL 12/28/12 updated 3/4/19