

# ANNUAL TUBERCULOSIS SCREENING QUESTIONNAIRE

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

Name \_\_\_\_\_ Date \_\_\_\_\_

Positive TB skin test (PPD) Date: \_\_\_\_\_

*OR*

Positive Quantiferon- Gold (QFT-G) date: \_\_\_\_\_

*If either PPD or QFT-G is positive- then:*

Last Chest X-Ray Date: \_\_\_\_\_ (result must be on file)

**Please indicate if you are having 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 _____ |
| 7. Night Sweats                         | Yes _____ | No _____ |
| 8. Shortness of Breath                  | Yes _____ | No _____ |

**NO EVIDENCE OF PULMONARY TUBERCULOSIS OR CONTAGIUM.**

Date \_\_\_\_\_

\_\_\_\_\_  
Agency Employee Signature

Date \_\_\_\_\_

\_\_\_\_\_  
Health Care Provider (M.D., D.O., N.P.)