



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)