Tuberculosis Symptom Questionnaire

Directions:

• Complete this form on an annual basis for those patients that are reactive to PPD’s.
• Complete the assessment for patients who convert their TB skin test.
• Complete the assessment for patients who refuse the annual TB assessment of skin test.
• Complete the assessment for new patients admitted without documented TB skin testing within 30 days prior to admission.
• Please document findings in the progress notes and on the record of immunization that this screening was completed.

Patient Name: ______________________________
ID Number: _________________________________
Unit: _______________________________________

Circle the symptoms that apply to this patient:

• Chronic cough
• Bloody sputum
• Unexplained weight loss
• Night sweats (drenching)
• Loss of appetite
• Fever (especially at night)
• Known exposure to TB
• Shortness of breath or chest pain
• Fatigue
• No Symptoms

Nurse signature: ________________________________
Date: ________________________________

-Use this assessment information when notifying physician and for transfer form to Reid rule out TB.
-Send form to the Infection Control Nurse.