

## Tuberculosis History Screening Questionnaire

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

Positive TB Skin Test (PPD) Date: \_\_\_\_\_

Last Chest X-Ray (attach report copy): \_\_\_\_\_

Please indicate if you are having any of the following problems for three to four weeks or longer:

- |   |                  |
|---|------------------|
| 1. Chronic Cough (greater than three 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

\_\_\_\_\_  
Agency Staff

\_\_\_\_\_  
Signature