



TB Screening Questionnaire

**Periodic/Post Exposure:
Last Tuberculin SkinTest Negative**

Last Name _____ **First Name** _____ **MI** _____ **Date Form Completed:** ____/____/____
Date of Birth ____/____/____
Department: In-Home Care **Job Title:** Home Care Aid **Home Phone** _____

1. Since your last TB skin test, have you worked in a location where patients with TB received care or services?
☐ Yes ☐ No ☐ Don't know
2. Since your last TB skin test, have you lived with or had close contact with someone who has TB?
☐ Yes ☐ No ☐ Don't know
3. Since your last TB skin test, has your negative test turned to a positive?
☐ Yes ☐ No ☐ Don't know
4. Since your last TB skin test, have you had an abnormal Chest x-ray?
☐ Yes ☐ No ☐ Don't know
5. Since your last TB skin test, has a health practitioner told you that your immune system isn't working or can't fight infection?
☐ Yes ☐ No ☐ Don't know
6. Do you work, volunteer, or live in another facility that provides medical or social services?
☐ Yes ☐ No ☐ Don't know
7. Since your last TB skin test, have you traveled outside the U.S.A.?
☐ Yes ☐ No ☐ Don't know
8. Since your last TB skin test, have you had any of the following symptoms for more than 3 weeks at a time?
(Please check all that apply)

☐ Persistent coughing	☐ Excessive fatigue	☐ Coughing up blood
☐ Hoarseness	☐ Excessive sweating at night	☐ Persistent fever
☐ Excessive weight loss	☐ NONE OF THE ABOVE	

THE ABOVE INFORMATION IS ACCURATE AND CORRECT:

Submit

EMPLOYEE SIGNATURE