

# OCCUPATIONAL ANNUAL TUBERCULOSIS QUESTIONNAIRE: SYMPTOM REVIEW

*This form is to be used with employees who have had a previous positive TB test and have already completed a medical evaluation where TB disease was ruled out. This questionnaire and review should be conducted annually.*

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ DOB \_\_\_\_\_

Employee ID/SSN \_\_\_\_\_ Department/Supervisor \_\_\_\_\_

Previous Positive Test Date \_\_\_\_\_ Type of Test \_\_\_\_\_

Have you ever taken medications as a follow-up to your positive TB test? Y N  
 If yes, did you complete the entire course of medications? Y N  
 Date treatment was completed: \_\_\_\_\_

Date of last chest X-ray \_\_\_\_\_ X-ray results \_\_\_\_\_

In the past year, have you entered a TB isolation room or had occupational exposure to a known case of TB? Y N  
 Specify location \_\_\_\_\_ Time/date of exposure \_\_\_\_\_

In the past year, have you lived with or had close contact with someone outside of work who has TB disease? Y N

In the past year, have you traveled and/or lived overseas? Y N  
 Where \_\_\_\_\_ Date(s) \_\_\_\_\_

In the past year, have you worked in or been a resident of a prison or a homeless shelter? Y N

In the past year, has a health practitioner told you that your immune system is suppressed or compromised? Y N

## Sign and Symptom Review

Unexplained coughing for more than two weeks (unrelated to smoking) Y N  
 Productive cough lasting longer than two weeks Y N  
 Blood in sputum Y N  
 Unexplained weight loss Y N  
 Unexplained fatigue Y N  
 Night sweats Y N  
 Fever not associated with an acute disease Y N  
 Loss of appetite Y N  
 Chest pains Y N  
 Shortness of breath Y N

For any YES answers, please give details (amount, time periods, etc) \_\_\_\_\_

Medical Eval Recommended: \_\_\_\_\_  
 Chest X-Ray Recommended: \_\_\_\_\_  
 Nurse's Initials: \_\_\_\_\_ Date: \_\_\_\_\_