

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. This is for employer use only, and not should not be returned to MDHHS.

First Name: _____ Last Name: _____ DOB: _____

Employee ID/SSN: _____ Department/Supervisor: _____

Previous Positive Test Date: _____ Type of Test: _____

1. 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: _____

2. Date of last chest X-ray: _____ X-ray results: _____

3. 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: _____

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

5. In the past year, have you traveled and/or lived overseas? Y N
 Where: _____ Date(s): _____

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

7. 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 on back (amount, time periods, etc.)*

Medical Eval Recommended: Y	N
Chest X-Ray Recommended: Y	N
Nurse's Initials: _____	Date: _____

