**ANNUAL TUBERCULOSIS SCREENING QUESTIONNAIRE**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Admission / Hire Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For residents and staff, if appropriate:**

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

Last Chest X-Ray Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For all residents and staff, please indicate if you are having any of the following problems, and they have continued for three weeks or longer:

1. Chronic Cough (greater than 3 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.**

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Resident / Employee Signature Date

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Licensed Nurse Signature Date