PRIMO
HEALTHCARE SERVICES

TB Screening Questionnaire

Employee Name: _____

This form is completed annually for those employees who have documentation of a negative TB skin test or chest x-ray following a positive Mantoux screening test, and whose medical evaluation and chest x-ray indicate that no further Mantoux screening is required.

Do you experience any of the following:	Yes	No
• bad cough that lasts longer than 2 weeks	☐	☐
• coughing up sputum (phlegm)	☐	☐
• coughing up blood	☐	☐
• loss of appetite	☐	☐
• weakness/fatigue/tiredness	☐	☐
• night sweats	☐	☐
• unexplained weight loss	☐	☐
• fever	☐	☐
• chills	☐	☐
• chest pain	☐	☐

- Have you recently spent time with someone who has infectious tuberculosis? ☐ Yes ☐ No

-Foreign-born person from **or** recent traveler to high-prevalence area ☐ Yes ☐ No

-Chest radiographs with fibrotic changes suggesting inactive or past TB ☐ Yes ☐ No

-HIV infection ☐ Yes ☐ No

-Organ transplant recipient ☐ Yes ☐ No

-Resident or employee of high-risk congregate setting (LTCF, Hospital) ☐ Yes ☐ No

-Immunosuppression due to medication or Chronic Disease ☐ Yes ☐ No

Any other complaints? ☐ Yes ☐ No If yes, explain: _____

_____

The above health statements are accurate to the best of my knowledge. I have been in-serviced on the signs and symptoms of tuberculosis and been advised to seek medical care if any of the symptoms develop at any time.

Employee Signature:_____ Date:_____

Nurse Reviewer Recommendation

☐ Refer employee TB/LTBI screening before continuing work.

☐ Refer employee for medical evaluation immediately, before continuing work.

☐ No action to be taken at this time.

RN Signature:_____ Date:_____