PROFESSIONAL NURSING SERVICE

TUBERCULOSIS SCREENING QUESTIONNAIRE

________________________________ ____________________
Name **Date**

Positive TB skin test (PPD) Date: ___________________________________

Last Chest X-Ray Date: ____

Please indicate if you are having any of the following problems for three to four 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.

_______________________ _______________________________
Date **Agency Employee Signature**

_______________________ _______________________________
Date **Physician Signature**