Annual Tuberculosis Health Questionnaire

Employee Name: _____ Date of Birth: _____ Phone: _____

Department: _____ Employee ID#: _____

1. In the last year, have you had any of the following symptoms?
   - Fatigue (tiredness and weakness) ☐ Yes ☐ No
   - Anorexia (loss of appetite) ☐ Yes ☐ No
   - Weight loss (unexplained) ☐ Yes ☐ No
   - Night sweats (unexplained) ☐ Yes ☐ No
   - Low grade fever (unexplained) ☐ Yes ☐ No
   - Productive cough (sputum) ☐ Yes ☐ No
   - Hemoptysis (blood in sputum) ☐ Yes ☐ No
   - Hoarseness (lasting 3 weeks or more) ☐ Yes ☐ No
2. Have you been told by a healthcare provider that your immune system is not working right or that you cannot fight infection? ☐ Yes ☐ No
3. Have you worked in a location where patients with active TB receive care or services? ☐ Yes ☐ No
4. Have you lived with or had close contact with someone who has TB disease? ☐ Yes ☐ No
5. Have you had an abnormal chest x-ray? ☐ Yes ☐ No
6. Have you worked, volunteered or lived in an institution such as another medical facility, jail, group home, or homeless shelter? ☐ Yes ☐ No
7. Have you received steroid treatment (oral, injection or nasal spray) in the past 6 weeks? ☐ Yes ☐ No
8. Have you had a live vaccine (MMR/Varicella) within the previous six weeks? ☐ Yes ☐ No
9. Have you lived or traveled outside of the United States in the last year? ☐ Yes ☐ No

If you answered 'Yes' to any of the questions above, please discuss with Employee Health or Infection Control. Educational materials are available from the Center of Disease Control which can be reviewed with Employee Health or Infection Control.

Employee Health staff is available at Blessing Hospital, Monday through Friday (8:00 am to 4:30 pm), extension 7950.

This questionnaire does not replace my obligation to report if diagnosed with TB disease.

_____ _____

Date *Employee Signature*

_____ _____

Date *Employee Health/Infection Control Signature*

BLESSING Health System