WakeMed

Occupational Health & Safety Services
Tuberculosis Symptom Screening Questionnaire

Last Name: ___________________ First Name: _________________ ID# ___________ D.O.B:___________

Please answer all questions and provide detail for any question that is answered with a yes.

1. Have you experienced any of the following symptoms in the past year?
   a) Productive cough for more than 3 weeks. □ Yes □ No
   b) Coughing up blood (Hemoptysis). □ Yes □ No
   c) Unexplained weight loss, unexplained fatigue (tiredness) □ Yes □ No
   d) Fever, chills, or night sweats for no know reason. □ Yes □ No
   e) Persistent shortness of breath, chest pain □ Yes □ No
2. Exposure to anyone with active tuberculosis in the past year? □ Yes □ No
3. Do you have a weakened immune system? □ Yes □ No
4. Do you take medications that may weaken your immune system? □ Yes □ No
5. Have you ever received a BCG vaccine? □ Yes □ No
6. Have you ever had a positive TB skin test? □ Yes □ No

If you answered "yes" to number 6, did you receive treatment? □ Yes □ No

If you answered "yes" to number 6, what is the date and location of your last chest x-ray?

Date______________________________ Location_________________________________

Please provide a detailed description to any questions answered "Yes."

I declare that my answers and statements are correctly recorded, complete, and true to the best of my knowledge. I understand if I develop any of the symptoms listed above, I am to contact the Occupational Health Office at 919-350-7370.

_______________________________________ _____________________________________

Signature Department

________________ Contact phone number: (____) _____-_____ □ Cell □ Home □ Office

Date

Office Use Only

________ No indication of active TB at this time. Date Reviewed: _____/_____/_____

________ Further evaluation needed. Date Employee Contacted: _____/_____/_____

Action Taken: ____

Date of follow-up exam: _____/_____/_____ Exam outcome: ____________________________________

Signature: ______________________________ Title: □ RN □ LPN □ MD □ Other ____________________________

Please Fax Your Completed Form to (919) 350-7874 or email to OccupationalHealth@wakemed.org