Tuberculosis Symptoms Screening Questionnaire

This form must be completed <u>annually</u> by a student with a history of a positive TB skin test.

<u>PLEASE PRINT</u>

Name: _____ Enrolled in Which Program?_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number(s): _____

Gender (circle): Male Female Birth date: month_____ day_____ year_____

Please answer the following questions.

Do you have:	Descriptions	Yes	No
1. Unexplained productive cough	*Cough greater than 3 weeks in duration*		
2. Unexplained fever	*Persistent temp elevations greater than one month*		
3. Night sweats	*Persistent sweating that leaves sheets and bedclothes wet*		
4. Shortness of breath/chest pain	*Presently having shortness of breath or chest pain*		
5. Unexplained weight loss/appetite loss	*Loss of appetite with unexplained weight loss*		
6. Unexplained fatigue	*Very tired for no reason*		

The above health statement is accurate to the best of my knowledge. I will see my doctor and/or health department if my health status changes.

_____ _____/_____/_____

Signature *Date*

<u>Action Taken by Program Advisor/Instructor</u>

*****Action taken after a *YES* answer to any question: _____

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