EDISON
HOME HEALTH CARE
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ANNUAL TUBERCULOSIS SCREENING QUESTIONNAIRE

Employee Name: _____ SS#: _____

Have you ever had a test for Tuberculosis? Yes_____ No_____

PPD/Mantoux Date: _____ Results: _____

TB QUESTIONNAIRE					
	Yes	**No**		**Yes**	**No**
Weakness			Persistent Cough		
Fatigue			Blood Streaked Sputum		
Lack of Appetite			Have you ever had a test for Tuberculosis?		
Weight Loss			Have you ever been exposed to someone who has had active tuberculosis?		
Low Grade Fever			If yes, did you receive treatment?		
Night Sweats			Color of Sputum (CIRCLE): Clear Yellow Other: _____		
Flu-Like Symptoms					
Chest Pain			***FOR CONVERSIONS (Must be filled out):***		
Shortness of Breath			**For Conversions Only:** OUTCOME: (Check one box only) ☐ LTBI treatment prescribed ☐ Pt. evaluated as TB suspect ☐ No treatment needed (due to_____) ☐ No treatment indicated (Low TB risk) ☐ Treatment not advised due to high risk of hepatitis ☐ Type of Treatment: _____ ☐ History of BCG ☐ Other: _____		
CHEST X-RAY (+PPD)			DATE:		RESULTS:

If I should notice any of the above signs or symptoms, I understand that I am to immediately notify my Physician and my Employer.

☐ No Follow up needed

☐ MD follow up needed. Refer to MD

_____

RN Signature **Date**

☐ This individual is free from any health impairment that is a potential risk to the patient or to other employee or which may interfere with the performance of his/her duties. He/she is not contagious to others and is medically cleared to work without restrictions.

Employee's Signature: _____ Date: _____

Doctor's Signature: _____Lic#_____ Date: _____YL 05/2013