# Tuberculosis Symptom Screening Questionnaire

1. **Have you experienced any of the following symptoms in the past year:**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.) A productive cough for more than 3 weeks?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.) Coughing up blood?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.) Unexplained weight loss?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d.) Fever, Chills, or night sweats for no known reason?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.) Persistent shortness of breath?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f.) Unexplained fatigue?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g.) Chest Pain?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. **Have you had contact with anyone with active tuberculosis disease in the past year?**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. **Do you have a medical condition, or are you taking medications, which suppress your immune system?**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Name of Employee** ___________________________________________

**Signature of Employee** ____________________________ **Date** ___________

**Evaluation:**

Upon review of the responses to the questionnaire and discussion with the person for whom the tuberculosis evaluation is required, I recommend as follows:

- **There is no indication this person has active tuberculosis at this time. A TB Skin Test is not indicated.**

- **Further evaluation, including a TB Skin Test, Interferon Gamma Release Assay or other medical evaluation is indicated.**

**Name of Evaluator** ___________________________________________

**Signature of Evaluator** ____________________________ **Date** ___________