Around the Clock®
Healthcare Services
"Staffing...wherever healthcare is provided."

INITIAL and ANNUAL TUBERCULOSIS SCREENING QUESTIONNAIRE

(This Form is to be used for those with a previously positive TB Skin Test, i.e., positive PPD.)

First Name:_____ **Middle Initial:**____ **Last Name:**_____

Positive TB Skin Test (PPD Date):_____

Date of Last Chest X-Ray:_____

Please indicate if you have had any of the following conditions for three to four weeks or longer:

SIGN OR SYMPTOM	YES	NO
Chronic Cough (greater than 3 weeks)		
Production of Sputum (productive cough)		
Blood Streaked Sputum		
Unexplained Weight Loss		
Unexplained Fever		
Weakness/Fatigue/Tiredness		
Loss of Appetite		
Night Sweats		
Shortness of Breath		
Chest Pain with Coughing		
Rapid Heart Rate (Tachycardia)		

NO EVIDENCE OF PULMONARY TUBERCULOSIS OR CONTAGIUM.

Applicant/Healthcare Associate Signature:_____ **Date:**_____

Physician Signature:_____ **Date:**_____

License Number_____

Clinic/Office Address:_____

Clinic/Office Telephone Number: _____