Tuberculosis Screening Questionnaire

Last Name _____ First Name _____ Date _____

Positive TB skin test (PPD) date _____ Last Chest X-Ray Date _____

Please indicate if you are having any of the following problems for three to four weeks or longer:

1. Chronic Cough (greater than 3 weks)	☐ Yes	☐ No
2. Production of Sputum	☐ Yes	☐ No
3. Blood-Streaked Sputum	☐ Yes	☐ No
4. Unexplained Weight Loss	☐ Yes	☐ No
5. Fever	☐ Yes	☐ No
6. Fatigue/Tiredness	☐ Yes	☐ No
7. Night Sweats	☐ Yes	☐ No
8. Shortness of Breath	☐ Yes	☐ No

Date _____ Signature _____

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