

**Tuberculosis Screening Questionnaire**

This questionnaire must be completed annually by employees with a history of a positive TB skin test (PPD). Please provide all the information requested below and return this questionnaire to your Staffing Coordinator.

Name:

Position:

Date of Positive PPD:

Date of Negative CXR :

**Please indicate if you have been experiencing any of the following symptoms for three weeks or longer:**

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. Productive Cough                                     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Blood-streaked Sputum                                | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Fatigue/Tiredness                                    | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. Unexplained Weight Loss                              | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Loss of Appetite                                     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6. Night Sweats   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7. Fever/Chills   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 8. Shortness of Breath                                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 9. Generalized Swollen Glands                           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 10. Any other unusual symptoms (if so, please explain)? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

I acknowledge and understand that First Assist, Inc. (the "Company" and its clients require the information provided above to make decisions regarding my employment with the Company and assignments to its clients. I authorize the Company to share this questionnaire with any First Assist client to which I am assigned or seek to be assigned.

\_\_\_\_\_  
 Employee Signature:

\_\_\_\_\_  
 Date:

\_\_\_\_\_  
 Signature of Examining Practitioner:

\_\_\_\_\_  
 Date:

Physician/Practitioner Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_