



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

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: _____