CORPCARE OCCUPATIONAL HEALTH

TUBERCULOSIS SCREENING QUESTIONNAIRE

Name_____ Date_____

Employer_____ Job Title_____

Tuberculosis also known as (TB) is a bacterial infection that can cause pneumonia, fever, weight loss and may involve other body systems. Some people who acquire the disease may be very ill while others may have no symptoms. It is transmitted in the air person to person. Control of the disease is based on early detection as well as treatment of exposed people with antibiotics. Skin tests such as PPD (Purified Protein Derivative) or blood tests (IGRA) may aid in the early diagnosis of exposure to TB.

Please answer the below prior to the PPD or IGRA test.

1. Have you ever had Tuberculosis? YES NO
2. Do you currently, or have you ever, experienced any of the following: Weight loss, bloody sputum, persistent fever, severe cough, loss of appetite, night sweats? YES NO
3. Have you ever had close contact with someone who has or had TB such as family member, co-worker or patient? Explain. YES NO
4. Have you ever received BCG (Bacillus Callmette-Guerin vaccine)? YES NO
5. Are you currently, or have you recently been treated with steroids or other medications that suppress the immune system? YES NO
6. Were you born, traveled or lived for at least 1 month in a country with an elevated TB rate? (NOT the US, Canada, Australia, New Zealand, western or northern Europe.) YES NO
   If yes please give details._____
7. Have you ever had a positive skin test for TB? YES NO
   If so, when_____
   Were you treated with medication, and if so for how long: _____
   Date of last Chest X-Ray:_____

Please provide details to any question answered "Yes".

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.

_____Further evaluation is recommended.

Provider signature/Date: _____

5/5/21