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ANNUAL TB SCREENING QUESTIONNAIRE

This form is intended to be used for employees or independent contractors with a previous positive skin test.

In the past 12 months, have you had:	YES	NO
✓ A persistent productive cough for 3+ weeks?	<input type="checkbox"/>	<input type="checkbox"/>
✓ Bloody sputum?	<input type="checkbox"/>	<input type="checkbox"/>
✓ Unexplained fatigue?	<input type="checkbox"/>	<input type="checkbox"/>
✓ Night sweats?	<input type="checkbox"/>	<input type="checkbox"/>
✓ Unexplained, recurrent fevers?	<input type="checkbox"/>	<input type="checkbox"/>
✓ Any change in your general health, such as diagnosis of diabetes or other chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>

Should any of these symptoms develop during the year, please notify your supervisor and alert your regular physician of your positive skin test.

Name _____
(Please Print)

Signed _____ Date _____
(Employee or Independent Contractor)