

B *BLESSING*

Corporate Services, Inc.

Annual Tuberculosis Health Questionnaire

Employee Name: _____ Date of Birth: _____ phone number _____

Department: _____ Employee ID#: _____

1. In the last year, have you had any of the following symptoms?

- Fatigue (tiredness and weakness) Yes No
- Anorexia (loss of appetite) Yes No
- Weight Loss (unexplained) Yes No
- Night sweats (unexplained) Yes No
- Low grade fever (unexplained) Yes No
- Productive cough (sputum) Yes No
- Hemoptysis (blood in sputum) Yes No
- Hoarseness (lasting 3 wks or more) Yes No

2. Have you been told by a health care provider that your immune system is not working right, or that you cannot fight infection? Yes No

3. Have you worked in a location where patients with active TB receive care or services?
Yes No

4. Have you lived with or had close contact with someone who has TB disease?
Yes No

5. Have you had an abnormal chest x-ray? Yes No

6. Have you worked, volunteered or lived in an institution such as another medical facility, jail, group home, or homeless shelter? Yes No

7. Have you received steroid treatment (oral, injection or nasal spray) in the past 6 weeks?
Yes No

8. Have you had a live vaccine (MMR/Varicella) within the previous six weeks?
Yes No

9. Have you lived or traveled outside of the United States in the last year?
Yes No

If you answered "Yes" to any of the above questions, please discuss with Employee Health or Infection Control. Educational materials are available from the Center for Disease Control which can be reviewed with Employee Health or Infection Control. Employee Health staff is available at Blessing Hospital, Monday – Friday (8:00 am to 4:30 pm), extension 6866 or 6865.

This questionnaire does not replace my obligation to report if diagnosed with TB disease.

Employee Signature: _____ Date: _____

Employee Health/Infection Control: _____ Date: _____