

Tuberculosis Screening Questionnaire

Name

Date of Birth

For medical professionals that have tested positive with TB skin testing and negative chest x-ray

Please indicate if you have had any of the following problems for three to four weeks or longer:

Chronic Cough (greater than three weeks): Yes No

Production of Sputum: Yes No

Blood Streaked Sputum: Yes No

Unexplained Weight Loss: Yes No

Fever: Yes No

Fatigue/Tiredness: Yes No

Night Sweats: Yes No

Shortness of Breath: Yes No

The information I have given is true and accurate AND THERE IS NO EVIDENCE OF PULMONARY TUBERCULOSIS OR CONTAGIUM.

Signature: _____ Date: _____

Return to:

Mail: Advanced Care Providers PO Box 972 Minocqua, WI 54548	Fax: 323-375-3290	Email: mike@acpstaff.com
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Please include a copy of your most recent Chest X-ray report.