SCHOOL OF NURSING
UT HEALTH SCIENCE CENTER®
EMPLOYEE HEALTH AND WELLNESS CLINIC

TB Screening Questionnaire

Periodic/Post-Exposure
History of Positive Tuberculin Skin Test

Last Name First Name Middle Initial

Date Form Completed ____/____/____
Mo Dy Yr

Date of Birth ____/____/____

UTHSC ID #_____

Department_____ Job Title_____ Work Phone _____

1. Since your last TB review, have you worked in a location where patients with active TB received care or service?

   [ ] Yes [ ] No [ ] Don't know

2. Since your last TB review, have you lived with or had close contact with someone who has TB disease?

   [ ] Yes [ ] No [ ] Don't know

3. Since your last TB review, have you had an abnormal chest x-ray?

   [ ] Yes [ ] No [ ] Don't know

4. Since your last TB review, has a health practitioner told you that your immune system isn't working right or can't fight infection?

   [ ] Yes [ ] No [ ] Don't know

5. Do you work, volunteer, or live in another facility that provides medical or social services?

   [ ] Yes [ ] No

6. Since your last TB review, have you traveled outside the U.S.A.?

   [ ] Yes [ ] No If yes, where and when? _____

7. Have you ever had any of the following symptoms for more than 3 weeks at a time? (Please check all that apply)

   [ ] Persistent coughing [ ] Excessive fatigue [ ] Coughing up blood
   [ ] Hoarseness [ ] Excessive sweating at night [ ] Persistent fever
   [ ] Excessive weight loss [ ] **None of the above**

THE ABOVE INFORMATION IS ACCURATE AND CORRECT: _____
EMPLOYEE SIGNATURE

Additional follow-up required due to findings (completed by Environmental Health & Safety):
[ ] Yes [ ] No

If yes, explain follow-up required:

_____

_____

_____

_____ _____
Signature **Date**