**Annual Symptom TB Screening**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_/\_\_\_\_/\_\_\_\_\_**

**Resident’s Last, first and middle initial Date of birth**

1. **Do you currently have any of the following symptoms?**

Cough lasting more than 3 weeks, unexplained? YES NO

Hemoptysis (coughing up blood) YES NO

Fever or chills, unexplained YES NO

Night sweats (sweating that leaves the bedclothes and sheets wet)? YES NO

Persistent shortness of breath, unexplained? YES NO

Chest pain, unexplained? YES NO

Weight loss, unexplained? YES NO

Fatigue, (feeling very tired) for no reason? YES NO

**2) Have you had contact with anyone with active tuberculosis disease in the past year?**

YES NO

**3) Do you have a medical condition or are you taking medications, which suppress your immune system?** YES NO

***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 currently.

\_\_\_\_\_\_\_ Further evaluation, including a TB Skin Test, Interferon Gamma Release Assay or other medical evaluation is indicated.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Healthcare Professional Signature Facility Name and Date

\_\_\_\_/\_\_\_\_/\_\_\_\_\_