Healthcare Personnel (HCP) Annual Symptom TB Screening

________________________________   ____/____/_____

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 TB 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"

The above health statement is accurate to the best of my knowledge. I will contact my health care professional and/or the health department if my health changes.

________________________________   ______________

HCP Signature   **Date**

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   Date

SPICE revised March 2021
https://spice.unc.edu/