

IF YOU HAVE EVER TESTED POSITIVE FOR TB, UPLOAD THIS FORM TO THE TB TEST TRACKER REQUIREMENT ALONG WITH CHEST X-RAY.

Questionnaire must be done annually. One x-ray is required upon admission to the nursing program unless you answer “Yes” on the form.

TB/PPD SCREENING QUESTIONNAIRE

Date: _____

Name _____ Date of Birth _____ GSW ID _____

Please answer the following questions by “checking” yes or no:	YES	NO
Have you had a new cough for the last 3 weeks?		
If you have a chronic cough, has it changed or become worse in the last 6 months?		
Do you ever cough up blood?		
Have you lost 10 pounds or more in the last 3-6 months?		
Do you sweat a great deal at night?		
Have you had unexpected fevers in the last 6 months?		
Have you been unusually tired?		
Had loss of appetite?		
Have you answered these questions honestly and to the best of your ability?		

Student/Patient signature: _____ *Date:* _____

Healthcare Professionals Only

Other action taken _____

Health care professional’s signature _____ Title _____ Date _____

Address _____ Telephone Number _____