Medical Staffing Solutions
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Forsyth Location
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ANNUAL TB QUESTIONNAIRE

Name: _____ Agency: _____
Birth Date: _____
Place a checkmark next to the appropriate symptoms you are experiencing or if any of the following apply to you.

	YES	NO
1) Do you cough up blood-streaked sputum?	___	___
2) Have you had a fever lasting several weeks?	___	___
3) Do you have night sweats?	___	___
4) Are you experience frequent coughing in absence of a cold or the flu?	___	___
5) Have you had unexplained weight loss?	___	___
6) Have you had unusual tiredness or weakness?	___	___
7) Any pain in your chest while taking a breath?	___	___
8) Have you recently been diagnosed with HIV, diabetes, silicosis, renal disease or liver disease?	___	___
9) Have you been recently exposed to a family member or others with active TB?		

If you checked Yes for any of the above questions, are you currently being treated by a medical doctor?

(Please circle the correct answer below)

YES NO

If you are not under medical supervision, please explain below why not:

Agency Employee
Signature_____Date_____