Pro Med
STAFFING, INC

Annual TB Questionnaire

Note: This Questionnaire should be completed only if you have tested positive for a TB test.

Name:_____ Date:_____

Address:_____ Phone:_____

Street City State Zip code

Social Security #:_____ Date of Birth:_____ Occupation:_____

Sex: Male Female Height:_____ Weight:_____

(Circle one)

Date of previous skin test:_____ Induration:_____

Date of last chest x-ray:_____ Results:_____

Date of last physical:_____

	YES	NO	IF YES, WHEN?
Have you ever had a positive TB skin test?			
Have you had a skin test conversion from negative to positive in the past 2 years?			
Have you ever had an abnormal chest x-ray?			
Have you ever been told you have pulmonary tuberculosis?			
Have you ever been treated with tuberculosis medications?			
Have you ever been treated with prophylaxis for positive skin test only?			
Do you have a productive, prolonged cough that lasted longer than 3 weeks?			
Do you cough up bloody sputum?			
Do you have a fever lasting longer than one week?			
Do you have chronic extreme fatigue?			
Do you have a loss of appetite?			
Do you have severe night sweats (need to change bedding/clothes because they are wet)?			
Have you lost weight (over 10 pounds) in the last 2 months without trying?			

I have answered these questions truthfully to the best of my knowledge. I fully understand the questions as asked.

_____ _____

Signature Date