AIM INDEPENDENT LIVING CENTER
Annual Tuberculosis Screening Questionnaire

This form is to be used annually when an employee has had a positive result occur from Tuberculosis screening using either skin testing or blood sample.

Name: _____

Positive TB skin test (PPD) Date: _____

Last Chest X-Ray Date: _____

Please indicate if you have experienced any of the following symptoms for 3 to 4 weeks or longer:

A chronic Cough for more than 3 weeks Yes _____ No _____

Production of sputum (mucus) Yes _____ No _____

Blood-Streaked sputum (mucus) Yes _____ No _____

Unexplained weight loss Yes _____ No _____

Night sweats Yes _____ No _____

Shortness of breath Yes _____ No _____

Have you had contact with anyone with active tuberculosis disease in the past year? Yes _____ No _____

I hereby certify that the above statements are true and answered to the best of my knowledge and ability. I hereby certify that I am capable of performing my job duties as detailed in my job description.

_____ _____

Employee Signature Date

Reviewed by: _____ Date: _____