Employee Health Services
Early Detection of Tuberculosis

This questionnaire gives guidance in identifying individuals with suspected or confirmed TB so that appropriate controls can be promptly initiated.

The questionnaire has two parts:
1. Reviewing the individual's TB history
2. Assessing current symptoms

INSTRUCTIONS:

- Check each answer given by patient
- Add your comments as the evaluator at the bottom of the page
- Institute the facility's exposure control measure outlined in the facility's Exposure Control Plan, Respiratory Protection and Medical Surveillance Program and refer the individual for further evaluation if the individual has:
  1. A persistent cough lasting 3 or more weeks and two or more symptoms of active TB.
  2. Had a positive TB test on mucous that he/she coughed up
  3. Been told that he/she had TB and was treated, but never finished the medication

TB History (Part One)

1. Have you ever had a positive TB skin test? YES ☐ NO ☐ DON'T KNOW ☐
2. Have you ever had an abnormal chest x-ray? YES ☐ NO ☐ DON'T KNOW ☐

   If YES, how long ago?
3. Have you recently had the mucous you cough up tested for TB? YES ☐ NO ☐ DON'T KNOW ☐

   If YES, were you told it was positive? YES ☐ NO ☐ DON'T KNOW ☐
4. Have you ever been told you have Infectious Tuberculosis? YES ☐ NO ☐ DON'T KNOW ☐

   If YES, how long ago?____
5. Have you ever been treated with medication for Infectious TB? YES ☐ NO ☐ DON'T KNOW ☐

   If YES, how many medications? ONE ☐ TWO ☐ OVER TWO ☐
6. Are you still taking TB medicine? YES ☐ NO ☐

   Did you take all the TB medicine until the health care professional told you that you were finished? YES ☐ NO ☐
7. Do you live with or have you been in close contact with someone who was recently diagnosed with TB? (e.g. shelter roommate, close friend, relative). YES ☐ NO ☐ DON'T KNOW ☐

CURRENT SYMPTOMS (Part Two)

	Question		
1.	Do you have a cough that has lasted longer than three weeks?	**YES** ☐	**NO** ☐
2.	Do you cough up blood or mucous?	**YES** ☐	**NO** ☐
3.	Have you lost your appetite? Aren’t hungry?	**YES** ☐	**NO** ☐
4.	Have you lost weight (more than 10 pounds) in the last two months without trying to?	**YES** ☐	**NO** ☐
5.	Do you have night sweats (need to change the sheets or your clothes because they are wet)?	**YES** ☐	**NO** ☐

Patient Signature:____ Date: ________________