Patient ATD Questionnaire

Today's Date: _____

Patient's Name: _____

Patient's Telephone Number: _____

Please complete and return questionnaire to the receptionist or attending healthcare personnel.

Please circle Yes or No

1. Have you had a cough for more than three weeks that is not explained by non-infectious conditions? **Y / N**

2. Do you have signs and symptoms of a flu-like illness during March through October, the months outside of the typical period for seasonal influenza, or exhibit these signs and symptoms for a period longer than two weeks at any time during the year? These signs and symptoms generally include combinations of the following: *coughing and other respiratory symptoms, fever, sweating, chills, muscle aches, weakness and malaise.* **Y / N**

3. Do you have a transmissible respiratory disease, excluding the common cold and seasonal influenza? **Y / N**

4. Have you been exposed to an infectious ATD case, other than seasonal influenza? **Y / N**

5. In addition to cough, have you experienced any of the following clinical symptoms of TB disease? **Y / N**

- Unexplained weight loss (>5lbs)
- Night Sweats
- Fever
- Chronic Fatigue/Malaise
- Coughing up blood

Please report any of the following illnesses immediately;

• Avian flu, novel flu, swine flu, or any other type of flu other than seasonal flu. • Chikenpox • Shingles • Measles • Monkeypox • Sars • Smallpox • Tuberculosis (TB) • Diphtheria • Haemophilus influenzae type b or Hib • Any new type of infectious illness	• Meningitis • Mumps • Pneumonia • Parvovirus • Pertussis or whooping cough • Pharyngitis • Epstein-Barr Virus • Strep • Scarlet fever