RNnetwork
Phone 561.862.0011 Toll Free 800.866.0407 Toll Free Fax 888-205-2402

Tuberculosis Screening Questionnaire

_____ _____
Name Date

Positive TB skin test (PPD) Date: _____

Last Chest X-Ray Date: _____

Please indicate if you are having any of the following problems for three to four weeks or longer:

1.	Chronic Cough (greater than 3 weeks)	Yes ____	No ____
2.	Do you cough up blood or have bloody sputum	Yes ____	No ____
3.	Have you had unexplained weight loss	Yes ____	No ____
4.	Do you have unexplained fever	Yes ____	No ____
5.	Do you have unexplained fatigue/tiredness	Yes ____	No ____
6.	Do you have recurrent night sweats	Yes ____	No ____
7.	Do you have shortness of breath	Yes ____	No ____

THERE IS NO EVIDENCE OF PULMONARY TUBERCULOSIS OR CONTAGIUM

_____ _____
Date Agency Employee Signature

_____ _____
Date Physician

4700 Exchange Court, Suite 125, Boca Raton FL 33431