Name: _____

Department or job of job shadow: _____

Date of job shadow: _____

Fort HealthCare
For Health

TB Screening Questionnaire-Shadow

Do you currently have a persistent productive cough or coughing up blood?	Y	N
Do you have a fever?	Y	N
Do you experience drenching night sweats?	Y	N
Have you had any unexplained weight loss in the past year?	Y	N
Do you have any unusual fatigue?	Y	N
Have you had any known exposure to tuberculosis?	Y	N
Have you traveled or lived outside the United States high -risk countries in (Central & South America, Africa, most of Asia) for more than 4 weeks?	Y	N

If yes, where and for how long? _____

_____

*If yes, a TB test is highly recommended.

Have you ever had a tuberculosis test (TB skin test or blood test)?	Y	N

If yes, when was the last TB test done? _____

Result: Positive Negative

If positive, did you require a chest x ray?	Y	N
Did you require treatment?	Y	N

If yes, what was the treatment_____

Have you been vaccinated for Tuberculosis?	Y	N

If yes, date of vaccination_____

Signature: _____Date: _____

* Please contact your physician or call Business Health Services at 920-568-5018 for further screening or testing.