CHI Health

EMPLOYEE HEALTH
TUBERCULOSIS (TB) SCREENING

Name	Date of Birth	Today's Date

TB RISK SCREENING QUESTIONS		
1.	Have you ever had a positive TB skin test or positive TB Quantiferon test?	☐ Yes ☐ No
2.	Have you ever been told you have/had TB or Tuberculosis?	☐ Yes ☐ No
	If yes, were you treated with Isoniazid (INH) or other medication?	☐ Yes ☐ No
	• Which drug? _____	
	• How long did you take it? _____	
3.	Have you ever had a chest x-ray?	☐ Yes ☐ No
	If yes, when/where was your last one done? _____	
4.	Have you ever had a Bacillus Calmette-Guerin (BCG) vaccine?	☐ Yes ☐ No
5.	Have you traveled to another country, not in the United States?	☐ Yes ☐ No
	If yes, list country(s) and year(s): _____	
6.	Have you had contact with or lived with person (s):	
	• With active TB disease?	☐ Yes ☐ No
	• Foreign-born persons from area of the world with high prevalence of TB?	☐ Yes ☐ No
TB SIGNS AND SYMPTOMS SCREENING QUESTIONS		
Do you currently have or have you ever had any of the following:		
7.	Coughing for more than three weeks?	☐ Yes ☐ No
8.	Unexplained loss of appetite?	☐ Yes ☐ No
9.	Unexplained weight loss or being more than 10 pounds below ideal body weight?	☐ Yes ☐ No
10.	Unexplained fever?	☐ Yes ☐ No
11.	Night sweats (not due to menopause)?	☐ Yes ☐ No
12.	Shortness of breath?	☐ Yes ☐ No
13.	Chest pain?	☐ Yes ☐ No
14.	Unexplained fatigue?	☐ Yes ☐ No
15.	Coughing up phlegm, blood or blood tinged phlegm?	☐ Yes ☐ No
16.	Diabetes?	☐ Yes ☐ No
17.	Gastrectomy (removal of stomach) or intestinal bypass?	☐ Yes ☐ No
18.	Chronic renal failure with renal dialysis?	☐ Yes ☐ No
19.	Silicosis (lung disease)?	☐ Yes ☐ No
20.	Immunosuppression from high-dose Steroid or other immunosuppressive therapy or malignancy (cancer)?	☐ Yes ☐ No

Form Completed by	Date

To be completed by Employee Health

Medical Staff Reviewing Form	Date

☐ No follow up required

☐ Employee contacted on (date): _____