8892 Beckett Road
Cincinnati, OH 45069
PH 866-301-4045
FAX 866-850-4048
www.advantagern.com

TUBERCULOSIS HISTORY SCREENING QUESTIONNAIRE

Please fill in this form and fax it back to **Advantage RN** at 866-850-4048.

This questionnaire is to be completed annually by those with known positive and documented PPD conversion or those with pulmonary symptoms suggestive of TB.

____

Full Name (Printed) Date

Positive TB skin test (PPD) Date: ______________________________

Last Chest X-Ray Date (attach report copy): ______________________________

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. Production of Sputum Yes _____ No _____
3. Blood Streaked Sputum Yes _____ No _____
4. Unexplained Weight Loss Yes _____ No _____
5. Fever Yes _____ No _____
6. Fatigue/Tiredness Yes _____ No _____
7. Night Sweats Yes _____ No _____
8. Shortness of Breath Yes _____ No _____

NO EVIDENCE OF PULMONARY TUBERCULOSIS OR CONTAGIUM.

____

Agency Employee Signature Date

____

Agency Staff Signature Date