Annual Tuberculosis Surveillance Questionnaire
Please print
Please retain a copy for your records as proof of annual tuberculosis screening
Fax to 215-456-1840

Last name _____ First name _____ MI __ Employee#_____

Date of birth _____ Work phone _____ Alternate phone _____

Department _____ Facility _____

Employee _____Volunteer _____ Other _____

This form should only be completed if you have a history of past positive TB skin test and/or other reasons which contraindicate tuberculosis skin testing at this time. Please check the correct option:

_____ Positive TST (TB skin test) Date of positive test _____ Check if unknown □

_____ BCG with past positive TST Date of positive test _____ Check if unknown □

_____ Other (explain): _____

I am completing this because of □ Annual requirement □ TB exposure

Routing chest x-rays are not performed to evaluate for status of tuberculosis. Symptom review is a better screening method for early detection of tuberculosis. Consequently, this brief questionnaire is very important. Please answer all questions at least once a year.

Have you had any of the following symptoms within the past year?

1.	Productive cough lasting longer than 3 weeks	Yes	No
2.	Shortness of breath	Yes	No
3.	Coughing up blood	Yes	No
4.	Chest pain	Yes	No
5.	Loss of appetite	Yes	No
6.	Unexplained weight loss	Yes	No
7.	Persistent low grade fever	Yes	No
8.	Unexplained night sweats	Yes	No
9.	Swollen glands, usually in the neck	Yes	No
10.	Recurrent kidney or bladder infections	Yes	No

Have you seen a provider and received treatment for latent or active TB in the past? Yes ___ No____

- If yes, date(s) of treatment_____

What is the date of your last chest x-ray to rule out tuberculosis? _____ Where? _____

- Is a copy on file at LiveWell Employee Health? Yes _____ No _____

Employee signature _____ Date _____

(For LiveWell Staff only) Reviewed by _____ _____ Date _____