URGENT MEDICAL
STAFFING SOLUTIONS

Tuberculosis History Screening Questionnaire

Full Name (printed): ______________________________________ Date_______________

Positive TB Skin Test – Date:____

Last chest x-ray - Date: ____

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

- *** Chronic Cough (greater than 3 weeks)** **Yes_____ No_____**
- *** Production of sputum** **Yes_____ No_____**
- *** Blood streaked sputum** **Yes_____ No_____**
- *** Unexplained weight loss** **Yes_____ No_____**
- *** Fever** **Yes_____ No_____**
- *** Fatigue/Tiredness** **Yes_____ No_____**
- *** Night sweats** **Yes_____ No_____**
- *** Shortness of breath** **Yes_____ No_____**

No evidence of Pulmonary Tuberculosis or Contagium.

Employee Signature____

Urgent Medical Staffing Solutions **Representative Signature_____________________________**

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