HEALTH ASSOCIATES
beyond expectations

Tuberculosis Annual Risk Assessment Screening Questionnaire

Temp Staff Name: _____ **Date:** _____

Have you ever had:

A complete course (at least 9 months) of INH therapy? If so please explain.	Yes _____	No _____
Active, untreated Tuberculosis	Yes _____	No _____
Acquired Immunodeficiency Syndrome (HIV)	Yes _____	No _____
Severe or poorly controlled diabetes mellitus	Yes _____	No _____
Any disease associated with severe immunologic deficiency	Yes _____	No _____
Silicosis (Obstructive lung disease associated with inhalation of silica	Yes _____	No _____
Gastrectomy (removal of part or all of the stomach)	Yes _____	No _____
Excessive alcohol intake	Yes _____	No _____

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

Chronic cough	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 _____

Close exposure to a case of communicable pulmonary tuberculosis in the past year Yes ___ No ___

NO EVIDENCE OF PULMONARY TUBERCULOSIS OR CONTAGIUM

_____ _____

Employee Signature Date