

E. TB Screening Questionnaire for Healthcare Workers

_____ Date Form Complete ____ / ____ / ____
Last Name First Name Middle Initial Mo Dy Yr
Date of Birth ____ / ____ / ____ Social Security Number ____ - ____ - ____
Department _____ Job Title _____ Work Phone _____

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**1. Please check the general category that best describes your current job title
[Develop facility-specific categories from the examples below]**

- Admitting Clerk Housekeeper Maintenance Worker
 Physician RN Respiratory Therapist

**2. Check one general category that best describes where you will spend most of the work day
[Develop facility-specific categories from the examples below]**

- Admitting/Registration Emergency Room Radiology
 Laboratory Pharmacy Many Locations

3. Were you born in the U.S.A.?

- Yes No

a. If no, what is your country of birth? _____

b. What year did you move to the U.S.A.? 19____ 20____ Don't know

4. Have you traveled or lived outside the U.S.A. in the last 2 years?

- Yes No

a. If yes, where? _____

5. Have you ever had a TB skin test? (Bubble under skin, not four-prong test)

- Yes No Don't know

a. If yes, when was your latest test? ____ / ____ / ____

b. What was the test result?

- Positive Negative Don't know

c. Do you have a copy of this result in writing?

- Yes No Don't know

d. If the test result was positive, what medication(s) did you take?

- Isoniazid None Other _____ Don't know

6. Have you ever had an IGRA blood test?

- Yes No Don't know
- a. If yes, when was your latest test? ____ / ____ / ____
- b. What was the test result?
 Positive Negative Indeterminate Don't know
- c. Do you have a copy of this result in writing?
 Yes No Don't know
- d. If the test result was positive, what medication(s) did you take?
 Isoniazid None Other _____ Don't know

7. Have you ever received BCG vaccine?

- Yes No Don't know

8. Have you ever been treated for TB disease?

- Yes No Don't know
- a. If yes:
1. In what year did you start treatment? 19 ____ 20 ____ Don't know
2. What medication did you take? _____
3. How long did you take this medication? _____

9. Have you ever had a chest x-ray?

- Yes No Don't know
- a. If yes, when was your last chest x-ray? _____

10. Has a health practitioner ever told you that your immune system isn't working right or can't fight infection?

- Yes No Don't know

11. Do you work, volunteer, or live in another facility that provides medical or social services?

- Yes No
- a. If yes, where? _____

12. Have you ever had any of the following symptoms for more than 3 weeks at a time? (Please check all that apply)

- Persistent coughing Excessive fatigue Excessive sweating at night
 Hoarseness Coughing up blood Persistent fever
 Excessive weight loss

Date TST Applied	Initials	Site (RA/LA)	Product Name	Lot #	Expiration Date	Dose (TU)	Date Read	Initials	Induration (mm)
__ / __ / __	_____	_____	_____	_____	__ / __ / __	_____	__ / __	_____	_____
__ / __ / __	_____	_____	_____	_____	__ / __ / __	_____	__ / __	_____	_____