All Heart
Homecare Agency

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Tel: 718.627.0300 Fax:718.627.0330

Employee Name: _____

Annual Tuberculosis Screening Questionnaire

1. Do you currently have any of the following signs or symptoms?

	YES	NO	COMMENTS
Weakness	_____	_____	_____
Fatigue	_____	_____	_____
Lack of Appetite	_____	_____	_____
Weight Loss	_____	_____	_____
Low Grade Fever	_____	_____	_____
Night Sweats	_____	_____	_____
Flu-Like Symptoms	_____	_____	_____
Chest Pain	_____	_____	_____
Shotness of Breath	_____	_____	_____
Persistent Cough	_____	_____	_____
Blood-Streaked Sputum	_____	_____	_____
Yellow or Dark Sputum	_____	_____	_____

2. Have you been exposed to anyone with the above signs or symptoms or who has had tuberculosis?

Yes ☐ No ☐

If I should notice any of the above signs or symptoms, I will notify my Primary Care Provider and my agency immediately.

Employee Signature _____ Date:

Primary Care Provider Signature: _____ Date:

(stamp)