C.H.T.Services,Inc.

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ANNUAL TUBERCULOSIS SCREENING QUESTIONNAIRE

Provider Name: ____ **SS#:** _____________________
Address:____
Have you ever had a test for Tuberculosis? **Yes** _____ **No** _____

PPD/Mantoux Date: _________________________ **Result:** ______________________

Chest X-Ray Date: ___________________________ **Result:** ______________________

Treatment Type: ____

Dates of Treatment: ____

Do you currently have any of the following symptoms?

Symptoms	Yes	No	Comments
Weakness	________	________	____________________________________
Fatigue	________	________	____________________________________
Lack of Appetite	________	________	____________________________________
Weight Loss	________	________	____________________________________
Low Grade Fever	________	________	____________________________________
Night Sweats	________	________	____________________________________
Flu-Like Symptoms	________	________	____________________________________
Chest Pain	________	________	____________________________________
Shortness of Breath	________	________	____________________________________
Persistent Cough	________	________	____________________________________
Blood Streaked Sputum	________	________	____________________________________

Color of Sputum (CIRCLE) **Clear** **Yellow** **Other:** _______________________

Have you ever been exposed to anyone exhibiting the above signs or symptoms, or someone who has had active tuberculosis? **Yes:** _____ **No:** _____

If yes, when and to whom were you exposed, and what type, if any, follow up treatment did you receive?
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If I should notice any of the above signs or symptoms, I understand that I am to immediately notify my Physician and my Employer.
Provider Signature: ____ **Date:** _________________