TB TEST/HEALTH HISTORY QUESTIONNAIRE
Advocate Occupational and Employee Health Centers

Name_____SS#_____Date _____/_____/_____
(please print)

Facility_____Dept Rotating With_____DOB_____/_____/_____

REASON FOR SCREENING *(Test or Questionnaire)*

❑ Pre-Placement ❑ Initial Exposure ❑ Post Exposure Follow-up
❑ Annual / Semi-annual ❑ Post Exposure Baseline ❑ Other _____

FIT TESTING *(for those who have been fit tested for the TB mask)*

Since your last fit test for the TB mask or respirator, check all that apply which may have altered the fit of your mask:

❑ New scarring on face (injury or surgery ❑ Facial fracture (nose, jaw, cheek)
❑ Significant weight loss or gain (over 10 lbs.) ❑ Have obtained dentures
❑ Have grown a beard or mustache ❑ Plastic surgery on face
❑ Neurologic deficit (Bell's palsy, stroke) ❑ No Change

Rotating Associate Signature *(required)* : _____

PPD TESTING

Have you taken steroids or chemotherapy in the past 6 weeks? ❑ Yes_____ ❑ No

People who have the following diseases are considered to have a positive TB skin test if induration is 5 mm or greater in size.
Have you been diagnosed as having any of the diseases listed below? Check all that apply.

❑ Diabetes ❑ Cancer ❑ Alcoholism
❑ Silicosis ❑ Hodgkin's ❑ Malabsorption Syndrome
❑ Immune deficiency ❑ Renal disease ❑ Recent gastrectomy

	Date Applied	Lot#	Applied by	Site	Date Read	(mm induration)	Read by
1st step	____/____/____	_____	_____	❑ R ❑ L	____/____/____	_____mm	_____
2nd	____/____/____	_____	_____	❑ R ❑ L	____/____/____	_____mm	_____

TB test must be read by the Employee Health Center or a TB Liaison 48 to 72 hours after test is placed.

TB HEALTH HISTORY QUESTIONS *(For those with history of positive TB reaction, record the following history but DO NOT RETEST! For follow-up questionnaires only complete section 3.)*

	Yes	No	Don't Know	
1.	❑	❑	❑	Have you ever had a positive TB test? If yes, when_____
	❑	❑	❑	Have you ever been treated with INH to prevent TB? If yes, for how long? _____
	❑	❑	❑	Have you ever received the BCG vaccine?
	❑	❑	❑	Have you ever had an abnormal chest x-ray? When? _____
2.				
	❑	❑	❑	Have you ever been told you have Infectious Tuberculosis? If yes, how long ago?_____
	❑	❑	❑	Have you ever been treated with medication for Infectious TB?
	❑	❑		Did you take all the TB Medicine until the physician told you that you were finished?
*3.	❑	❑		Do you currently have a cough that has lasted longer than three weeks?
	❑	❑		Do you cough up blood or mucous?
	❑	❑		If yes, have you recently had the mucous you cough up tested for TB?
	❑	❑		If yes, were you told it was positive?
	❑	❑		Have you had a decrease in your appetite? Aren't hungry?
	❑	❑		Have you lost weight (over 10 pounds) in the last 2 months without trying?
	❑	❑		Do you have night sweats (need to change the sheets or your clothes because they are wet)?
	❑	❑	❑	Do you live with or have you been in close contact with someone who was recently diagnosed with TB (e.g. roommate, close friend, relative)?

❑ ❑ Have you been diagnosed with Infectious TB since completing your last TB questionnaire?