Tuberculosis Screening Assessment

Please circle the answer to each question. This assessment will be placed in you personnel file and will remain strictly confidential. Thank you!

1. Were you born in the United States? YES NO
   If not, in what country were you born?_____

2. Have you traveled outside the United States within the last year? YES NO

3. Do you have any reason to believe that you have Been in contact with someone who has active TB? YES NO

4. Have you ever been diagnosed or received treatment for TB? YES NO

5. Do you currently have a persistent cough that has lasted longer than 2 weeks? YES NO

6. Do you currently have night sweats? YES NO

7. Have you lost weight without dieting? YES NO

8. Have you ever coughed up blood? YES NO

9. Do you currently have unexplained fevers? YES NO

I acknowledge that the above information is true and correct.

_____ _____ _____

Print Name of Staff / Volunteer Signature of Staff / Volunteer Date

Reviewed by Health Specialist on _____(date) Referral Yes ___ No___

___ At this time, the above named person has no apparent signs or symptoms of active TB and there is no reason to have an additional TB screening.

_____

DACHS Staff Signature