McLaren Medical Group

TB Screening Questionnaire

Employee Use Only:
Dept: _____
❑New Hire ❑Semi-Annual ❑Annual ❑Past Positive Questionnaire
Post Exposure Date ___/___/___

Please read and answer the following questions very carefully:

Have you ever been told you had TB?	❑ Yes	❑ No
Have you ever lived with anyone with TB?	❑ Yes	❑ No
Have you had close contact with a person with TB?	❑ Yes	❑ No
Have you ever had a positive TB test?	❑ Yes	❑ No
Have you taken TB medications after a positive TB test?	❑ Yes	❑ No
Have you received a live virus vaccine in the past 4-6 weeks?	❑ Yes	❑ No
Were you born outside of the United States?	❑ Yes	❑ No
Have you traveled outside of the United States (other than Canada, New Zealand, Western Europe or Australia) ?	❑ Yes	❑ No
Have you ever received BCG vaccinations?	❑ Yes	❑ No
Have you ever lived in a long term care, correctional facility, or shelter?	❑ Yes	❑ No
Have you had close contact with someone who was in a Long Term Care Facility, Correctional Facility or Shelter within the last 5 years?	❑ Yes	❑ No
Have you ever injected illicit drugs?	❑ Yes	❑ No
Are you frequently exposed to anyone who injects illicit drugs?	❑ Yes	❑ No
Are you frequently exposed to anyone who has HIV (AIDS virus)?	❑ Yes	❑ No
Are you frequently exposed to migrant farm workers?	❑ Yes	❑ No
Have you had contact with anyone visiting from a foreign country?	❑ Yes	❑ No
Have you had a recent viral infection?	❑ Yes	❑ No

Please check if you have any of these symptoms (symptoms of TB) and DO NOT know the cause:

❑ Cough w/sputum or blood for more than 2 weeks ❑ Night sweats ❑ Shortness of breath
❑ Unexplained weight loss/Appetite loss ❑ Fever/Chills ❑ Fatigue ❑ Chest pain

Please check if you have the following health problems or are taking any of these medications

❑ Any Immune-compromising conditions ❑ Currently taking steroids
❑ Currently taking Chemotherapy ❑ HIV positive or at risk for HIV

By signing in the space below, I am agreeing to the following statements:

> To the best of my knowledge, I have answered all of the above questions correctly.
> I understand the TB screening program and need to have my test read in 48 to 72 hours. If I do not return within 72 hours, I will need to have the test re-done.
> (For employees only) I agree to inform the Employee Health Nurse, if I develop any symptoms of TB before my next TB screening.

Patient/Employee/Parent Signature: _____ Date: _____

Physician Signature: _____ Date/Time: _____

Risk Evaluation:

❑ Test immediately
❑ Test immediately and annually while risks exists.
❑ Begin treatment
❑ No risk, no testing needed

Patient Name:

Date of Birth:

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