# Employee TB
# Sign & Symptom Review

Use this form with employees who have history of a previous positive TB test and have already completed a medical evaluation where TB disease was ruled out.‡
This questionnaire and review should be conducted annually.

Name: _____ DOB: _____

Company Name:_____ Date form completed: _____

Employee ID/SSN: _____

Previous positive test date: _____ □ QUANT □ TST ( _____ mm induration)

Date of last chest x-ray: _____ x-ray result: _____

Have you ever taken medications as a follow-up to your positive TB test? Yes No

If YES, did you complete the entire course of medications? Yes No

Date treatment completed: _____

*If at any time you experience symptoms of potential TB, immediately notify your supervisior

| Sign and Symptom Review<br>*Since your last TB test, have you experienced any of the following symptoms for more than two weeks at a time?* | | |
|---|---|---|
| Unexplained cough | Yes | No |
| Productive cough | Yes | No |
| Blood in sputum | Yes | No |
| Unexplained weight loss | Yes | No |
| Unexplained fatigue | Yes | No |
| Excessive sweating at night | Yes | No |
| Fever not associated with an acute disease | Yes | No |
| Loss of appetite | Yes | No |
| Chest pain | Yes | No |
| Shortness of breath | Yes | No |
| Productive or prolonged cough (over 2 weeks duration) | Yes | No |
| Recurrent pneumonia | Yes | No |
| Unprotected exposure to a known TB Patient<br>Date of exposure: _____ | Yes | No |

If yes, to any of the above. Please explain, include onset and duration:_____

_____

Medical Evaluation and Chest X-Ray Recommended Yes No

_____ _____ _____

Healthcare Provider (Print Name) Healthcare Signature Date