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TUBERCULOSIS QUESTIONNAIRE

Date : ____/____/____

Name : _____ Date of Birth : _____

1. Have you been vaccinated against tuberculosis with BCG? Yes No

If yes:

When? ____/____/____

Where? _____

2. Have you had a TB Skin Test? Yes No

3. If you answered yes in No. 2, date of your last TB Skin Test. ____/____/____

	HS System	Private Doctor	Self
Who administered the test?			
Who interpreted the results?			

What was the TB Test Result? No Reaction Reactive

Can you provide documentation for this test result? Yes No

4. If your test result was REACTIVE, were you advised

to take any medication ? Yes No

Name of Medication prescribed. _____

How long did you take it? _____

5. When was your last chest x-ray? ____/____/____

Result: Negative for TB Active TB

6. Were you ever treated for Tuberculosis? Yes No

If YES, when: ____/____/____

7. 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	_____	_____	_____
Clear, Yellow or Dark Sputum	_____	_____	_____

8. TUBERCULIN TEST _____

PPD/Mantoux Date _____ Result _____

Chest X-Ray Date _____ Result _____

9. Have you been exposed to anyone with the above signs or symptoms or who has had tuberculosis?

YES _____ or NO _____

IF I SHOULD NOTICE ANY OF THE ABOVE SIGNS OR SYMPTOMS, I WILL IMMEDIATELY NOTIFY MY PHYSICIAN AND SUPERVISOR OF MY AGENCY.

Employee Signature

Date

Physician Name & Signature

Date

OR

RN Name & Signature

Date