SCOTLAND HEALTH CARE SYSTEM
Closer Care. Better by Far.

TB Questionnaire

Associate Name _____ **Last 4 Digits SSN:** _____

Department Name: _____ **Date of Birth:** ___/___/_____

Directions:

This form should be used for your TB screen only if you have a documented positive TB skin test or you do not provide direct patient care. Complete the following questions. Your answers will be reviewed by the Associate Health Nurse. This will help identify any symptoms of active TB. If further action is needed, you will be contacted by Associate Health.

To be reviewed by your Nurse Manager or the Associate Health Nurse.

Reason completed: (Check one) ☐ Routine ☐ TB Exposure ☐ Pre-Employment

In the past year, have you experienced or do you now have any of the following symptoms?

Yes	No		Yes	No	
☐	☐	Blood Tinged Sputum	☐	☐	Pleural Pain
☐	☐	Chronic Cough	☐	☐	Weight Loss
☐	☐	Night Sweats			

Do you have or have you had in the past year, any of the following?

Yes	No		Yes	No	
☐	☐	Cancer	☐	☐	Pneumonia
☐	☐	Chronic Lung Disorder	☐	☐	Sarcoidosis
☐	☐	Diabetes (Insulin Dependent)	☐	☐	Sickle Cell Anemia
☐	☐	Immunocompromised condition	☐	☐	Stomach Surgery

_____ _____/_____/_____

Associate Signature **Date**

To be filled out by Associate Health Nurse:

☐ No chest x-ray necessary

☐ Ordered chest x-ray

_____ _____/_____/_____

Associate Health Signature **Date**

Fax completed form to Associate Health at (910) 291-7564.
Please check fax receipt to verify successful transmission.