

TB TEST/HEALTH HISTORY QUESTIONNAIRE

Advocate Occupational and Employee Health Centers

Name _____ SS# _____ Date ____/____/____
(please print)

Facility _____ Dept Rotating With _____ DOB ____/____/____

REASON FOR SCREENING (*Test or Questionnaire*)

- | | | |
|---|---|--|
| <input type="checkbox"/> Pre-Placement | <input type="checkbox"/> Initial Exposure | <input type="checkbox"/> Post Exposure Follow-up |
| <input type="checkbox"/> Annual / Semi-annual | <input type="checkbox"/> Post Exposure Baseline | <input type="checkbox"/> Other _____ |

FIT TESTING (*for those who have been fit tested for the TB mask*)

Since your last fit test for the TB mask or respirator, check all that apply which may have altered the fit of your mask:

- | | |
|---|---|
| <input type="checkbox"/> New scarring on face (injury or surgery) | <input type="checkbox"/> Facial fracture (nose, jaw, cheek) |
| <input type="checkbox"/> Significant weight loss or gain (over 10 lbs.) | <input type="checkbox"/> Have obtained dentures |
| <input type="checkbox"/> Have grown a beard or mustache | <input type="checkbox"/> Plastic surgery on face |
| <input type="checkbox"/> Neurologic deficit (Bell's palsy, stroke) | <input type="checkbox"/> No Change |

Rotating Associate Signature (*required*): _____

PPD TESTING

Have you taken steroids or chemotherapy in the past 6 weeks? Yes _____ No

People who have the following diseases are considered to have a positive TB skin test if induration is 5 mm or greater in size.

Have you been diagnosed as having any of the diseases listed below? Check all that apply.

- | | | |
|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Silicosis | <input type="checkbox"/> Hodgkin's | <input type="checkbox"/> Malabsorption Syndrome |
| <input type="checkbox"/> Immune deficiency | <input type="checkbox"/> Renal disease | <input type="checkbox"/> Recent gastrectomy |

	Date Applied	Lot#	Applied by	Site	Date Read	(mm induration)	Read by
1 st step	____/____/____	_____	_____	<input type="checkbox"/> R <input type="checkbox"/> L	____/____/____	_____ mm	_____
2 nd	____/____/____	_____	_____	<input type="checkbox"/> R <input type="checkbox"/> L	____/____/____	_____ mm	_____

TB test must be read by the Employee Health Center or a TB Liaison 48 to 72 hours after test is placed.

TB HEALTH HISTORY QUESTIONS (*For those with history of positive TB reaction, record the following history but DO NOT RETEST! For follow-up questionnaires only complete section 3.*)

- | | Yes | No | Don't Know | |
|-----|--------------------------|--------------------------|--------------------------|---|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a positive TB test? If yes, when _____ |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been treated with INH to prevent TB? If yes, for how long? _____ |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever received the BCG vaccine? |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an abnormal chest x-ray? When? _____ |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been told you have Infectious Tuberculosis? If yes, how long ago? _____ |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been treated with medication for Infectious TB? |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Did you take all the TB Medicine until the physician told you that you were finished? |
| *3. | <input type="checkbox"/> | <input type="checkbox"/> | | Do you currently have a cough that has lasted longer than three weeks? |
| | <input type="checkbox"/> | <input type="checkbox"/> | | Do you cough up blood or mucous? |
| | <input type="checkbox"/> | <input type="checkbox"/> | | If yes, have you recently had the mucous you cough up tested for TB? |
| | <input type="checkbox"/> | <input type="checkbox"/> | | If yes, were you told it was positive? |
| | <input type="checkbox"/> | <input type="checkbox"/> | | Have you had a decrease in your appetite? Aren't hungry? |
| | <input type="checkbox"/> | <input type="checkbox"/> | | Have you lost weight (over 10 pounds) in the last 2 months without trying? |
| | <input type="checkbox"/> | <input type="checkbox"/> | | Do you have night sweats (need to change the sheets or your clothes because they are wet)? |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you live with or have you been in close contact with someone who was recently diagnosed with TB (e.g. roommate, close friend, relative)? |



Have you been diagnosed with Infectious TB since completing your last TB questionnaire?