College of Health and Human Services
Department of Baccalaureate Nursing
Annual TB Assessment - Faculty
Mandatory for known positive TB screeners with negative chest x-rays and/or negative Quantiferon Tb-Gold blood tests

NAME: _____ DATE: _____

Complete the following questionnaire by checking the correct response to the questions:

1. Were you vaccinated with BCG as a child? Yes_____ No_____
2. Have you ever been diagnosed with TB and received treatment? Yes_____ No_____
3. Have you knowingly been exposed to a person diagnosed with TB within the past year? Yes_____ No_____
4. Have you been evaluated for pulmonary symptoms suggestive of TB in the last year? Yes_____ No_____
5. Have you had a bad cough lasting longer than three (3) weeks? Yes_____ No_____
6. Have you been coughing up blood, yellow, or green sputum? Yes_____ No_____
7. Have you experienced any excessive sweating at night or chills at night? Yes_____ No_____
8. Have you experienced excessive fatigue, weakness, or fever? Yes_____ No_____
9. Have you had unexplained weight loss in recent months? Yes_____ No_____
10. Have you had any unexplained loss of appetite in recent months? Yes_____ No_____

If you answered yes to any of the questions, please comment below and give dates of any events.

IT IS YOUR RESPONSIBILITY TO COMPLETE AND SIGN THE FORM ANNUALLY AND SUBMIT IT TO THE DEPARTMENT OFFICE – RM 325. ADDITIONAL MEDICAL FOLLOW-UP MAY BE REQUIRED AFTER DEPARTMENTAL REVIEW OF THIS FORM.

_____ _____
Signature Date