TUBERCULOSIS (TB) SURVEILLANCE FORM

TB Skin Test (PPD) Date Given:_____ Date Read: _____

Last Chest X-Ray Date: _____

Please indicate if you are having any of the following problems for three to four weeks longer (Answer YES for any UNEXPLAINED symptom!):

1.	Chronic cough (greater than 3 weeks)	☐ Yes	☐ No
2.	Production of Sputum	☐ Yes	☐ No
3.	Blood Streaked Sputum	☐ Yes	☐ No
4.	Unexplained Weight Loss	☐ Yes	☐ No
5.	Fever lasting more than 3 days	☐ Yes	☐ No
6.	Fatigue/Tiredness	☐ Yes	☐ No
7.	Chest Pain	☐ Yes	☐ No
8.	Night Sweats	☐ Yes	☐ No
9.	Shortness of Breath	☐ Yes	☐ No

If you answered YES to any of the above, please explain below:

_____

_____

If you answer YES to any of the questions above, you are required to have a physician's clearance prior to working.

PRINTED NAME: _____ TITLE: _____

SIGNATURE: _____ DATE:_____