

Tuberculosis Questionnaire

Name: _____ SSN: _____

Interview Date: _____ Interviewed By: _____

Date of Positive PPD: _____ Date of Last Chest X-ray: _____

INH: Yes No When Taken: _____ How Long Taken: _____

Check the appropriate response for any symptoms you may be experiencing:

- | | | |
|-----------------------------------|------------------------------|-----------------------------|
| 1) Unexplained weight loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2) Anorexia (loss of appetite) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3) Fever (usually at night) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4) Night sweats (drenching) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5) Cough (> 2 weeks) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6) Hemoptysis (spitting up blood) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7) Production of sputum | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8) Fatigue/tiredness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9) Shortness of breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you answered yes to any of the above listed symptoms, please indicate the symptom number and a brief explanation regarding this symptom:

Symptom #

Explanation

_____	_____
_____	_____
_____	_____
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Signature: _____

Date: _____

