TOTAL URGENT CARE
Occupational Medicine
314 Highway 3162
Cut Off, LA 70433
Phone: (985) 632-1820 Fax: (985) 632-1824

TUBERCULOSIS SCREENING QUESTIONNAIRE

Name: _____Date: _____

DOB: _____ SSN: _____ Employer: _____

Any candidate who submits a chest x-ray as proof of their Tuberculosis screening due to a past positive TB skin test **must** complete the following Questionnaire on an annual basis. Please complete the information below and submit the completed form with the documentation of the most recent chest x-ray.

Date of positive TB test: _____ Date of last chest x-ray:_____

Have you ever taken medication for tuberculosis? YES NO Name of Med: _____

Since your last chest x-ray have you had any of the following symptoms for 3-4 weeks or longer?

Productive cough for 3 weeks or more?	YES	NO	Still Have? ____
Persistent weight loss without dieting?	YES	NO	Still Have? ____
Loss of appetite?	YES	NO	Still Have? ____
Persistent fever above 100 F?	YES	NO	Still Have? ____
Night Sweats?	YES	NO	Still Have? ____
Swollen glands in neck or elsewhere?	YES	NO	Still Have? ____
Recurrent/persistent kidney/bladder infections?	YES	NO	Still Have? ____
Coughing up blood (hemoptysis)?	YES	NO	Still Have? ____
Shortness of breath?	YES	NO	Still Have? ____
Chest pains?	YES	NO	Still Have? ____
Fatigue or weakness of felling ill?	YES	NO	Still Have? ____
Frequent of recurring chills?	YES	NO	Still Have? ____

The above health statement is true and accurate to the best of my knowledge. I will visit my Health Care Provider or Parish Health Unit if my health status should change.

Patient Signature: _____Date: _____

Provider Notes : _____

_____

_____

Provider Signature: _____ Date: _____