Employee Health TB Screen Form
"Symptom Checklist"

Name: ________________________ **D.O.B.** _________________ **Date:** ____________________

Position: _______________________ **Dept/Office:** ____________ **Phone #:** __________________

Circle one: Employee Volunteer Contracted Employee Other ____________________

TB Exposure: Have you been exposed to anyone with active TB in past year
___ Yes ___ Not that I am aware of ___ Possibly

TB Test History:
__ Positive PPD
__ Positive PPD, Negative QuantiFERON GOLD blood test prior to hire
__ Positive PPD, Negative Chest X-Ray prior to hire
__ Hx of Prior TB or TB Exposure Treatment
__ Completing this in place of PPD due to current shortage
__ Other ____

Check all that apply:

- ☐ I am a diabetic
- ☐ I have a history of blood/lymphatic disease (such as Leukemia, Hodgkins)
- ☐ I take corticosteroids such as prednisone, Decadron or other steroids.
- ☐ I take immunosuppressive drugs (azathioprine, cyclosporine, muromonab, etc.)

Have you experienced any of these symptoms in the past year? (Circle all that apply)

Fever	Tired (fatigue)	Lethargic
Loss of Appetite	Unexplained weight loss	Swelling in the neck, armpit, or groin
Cough with sputum	Blood tinged sputum	Night sweats
Weakness	None of the above apply to me	

Are these symptoms current or old? ____

**I understand the signs & symptoms of TB and that I am at increased risk, and therefore will notify my supervisor if I develop any of these symptoms. _______ (employee initials)

Employee: Signature: ____**Date:**__________________________

Note: Anyone with 2 or more symptoms must be referred to the Medical Director for clearance

Date of last negative chest x-ray: _________________________

Date of last negative QuantiFERON GOLD blood test: _________________________

A. Cleared B. Not Cleared, Medical Director has been notified (Circle A or B)

__________________________ ____________________________ __________________

Provider Name Provider Signature Date:

Form D1 Updated 12/26/2019