

COMMUNICABLE DISEASE QUESTIONNAIRE

Name

Date

Positive TB skin test (PPD) date: _____

Last Chest X-Ray date: _____ Results: _____

Please indicate if you have been having any of the following problems for three to four weeks or longer:

- | | |
|---|--------------------|
| 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 | Yes _____ No _____ |
| 6. Fatigue/Tiredness | Yes _____ No _____ |
| 7. Night Sweats | Yes _____ No _____ |
| 8. Shortness of Breath | Yes _____ No _____ |

NO EVIDENCE OF PULMONARY TUBERCULOSIS OR CONTAGIUM

Date

Agency Employee Signature

Date

Agency Staff Signature

Date

Physician Signature

(Applicable to only those facilities who have this as a requirement)