CELIA'S HOUSE
IN HOLMES PARK

TB Screening Form

1. Have you experienced any of the following symptoms in the past year?

a.) A productive cough for more than 3 weeks?	☐ Yes	☐ No
b.) Hemoptysis (coughing up blood)?	☐ Yes	☐ No
c.) Unexplained weight loss?	☐ Yes	☐ No
d.) Fever, Chills, or night sweats for no known reason?	☐ Yes	☐ No
e.) Persistent shortness of breath?	☐ Yes	☐ No
f.) Unexplained fatigue?	☐ Yes	☐ No
g.) Chest Pain?	☐ Yes	☐ No

2. Have you had contact with anyone with active tuberculosis disease in the past year?
☐ Yes ☐ No

3) Do you have a medical condition, or are you taking medications, which suppress your immune system? ☐ Yes ☐ No

_____

Please provide details to any question answered "**Yes**". I declare that my answers and statements are correctly recorded, complete, and true to the best of my knowledge.

_____
_____
_____
_____

Referred for TB testing? ☐ Yes ☐ No HR/Nurse signature: _____

Signature: _____

Printed Name: _____ Date: _____