Unique Health Care LLC

Consent & Release for TB Screening

Check YES or NO as to whether you currently have any of the symptoms listed below.

Employee Name: _____Date: _____

1. Persistent cough, lasting longer than 3 weeks? ____ Yes ___ No
2. Blood tinged sputum ____ Yes ___ No
3. Fever/chills ____ Yes ___ No
4. Weight loss/poor appetite ____ Yes ___ No
5. Night sweats ____ Yes ___ No
6. Profound weakness or fatigue ____ Yes ___ No
7. Chest Pain ____ Yes ___ No
8. Pneumonia, bronchitis, etc. that has not cleared up with antibiotics ____ Yes ___
9. No Have you ever had an adverse reaction or positive reaction to a TB skin test? ____ Yes ___ No
10. Were you born outside of the US? ____ Yes ___ No
11. Have you traveled or lived outside of the US in the past 2 years? ____ Yes ___ No
12. Have you ever had the BCG vaccine? ____ Yes ___ No
13. Have you ever been treated for latent or active TB? ____ Yes ___ No

Comments related to “yes” answers above: _____

Employee Signature _____Date_____

Questionnaire reviewed by _____Date_____