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T B Questionnaire

Employee Name: _____ Date: 3/10/2008

New ISS employees with a history of a positive reaction to a previous PPD shall provide a report from a physician indicating that X-rays of the chest taken within the previous 12 months were negative for TB or must have chest films made and read before starting any patient-related activities. All employees also must complete an annual TB Questionnaire. (This program is based on the U.S. Department of Health and Human Services, CDC Recommendations and Reports of October 28, 1994).

Positive TB skin test (PPD) Date: _____ Last Chest X-Ray Date: _____

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

| | <u>Yes</u> | <u>No</u> |
|---|------------|-----------|
| 1. Chronic Cough lasting longer than three weeks..... | _____ | _____ |
| 2. Chills that recur..... | _____ | _____ |
| 3. Unexplained Weight Loss (over 10 lbs. in 2 months)..... | _____ | _____ |
| 4. Night sweats..... | _____ | _____ |
| 5. Fever lasting several weeks..... | _____ | _____ |
| 6. Coughing blood-streaked sputum..... | _____ | _____ |
| 7. Fatigue – easily and ongoing..... | _____ | _____ |
| 8. Shortness of Breath..... | _____ | _____ |
| 9. Have you been recently diagnosed with diabetes, silicosis, HIV disease, renal disease or liver disease?..... | _____ | _____ |
| 10. Have you recently been exposed to a family member or other person with active TB?..... | _____ | _____ |
| 11. Have you ever received the BCG immunization?..... | _____ | _____ |

If you checked YES to any of the above questions, are you currently being treated by a Physician?: Yes No (Circle one). Please explain:

I UNDERSTAND THAT I MUST REPORT THE DEVELOPMENT OF ANY SYMPTOMS OF TB LISTED ABOVE TO A PHYSICIAN AND ISS IMMEDIATELY. A CHEST X-RAY MUST BE PERFORMED PRIOR TO WORKING AGAIN.

Employee Signature

Date

Physician Signature

Date