



Appendix F

ANNUAL POSITIVE TB SKINTEST QUESTIONNAIRE

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 days	_____	_____
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 or No (circle one). Please explain:

Any additional symptoms:

I have indicated the symptoms above and have no additional symptoms at this time:

Student Signature: _____ Date: _____

Print Name: _____

By signing below, I affirm that the student is not exhibiting any TB symptoms that would be inappropriate for the FNP clinical experience.

Healthcare Provider Printed Name:	
Certification (circle):	MD / DO / NP / RA / RN
Signature	Date