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:

	Yes	No
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 field experience.

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

Please provide provider/clinic stamp.