SANILAC COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

# ANNUAL TUBERCULOSIS HEALTH QUESTIONNAIRE

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| Staff Name: | |
| *This form must be completed & returned to Human Resources* | |
| ***Please indicate by checking “YES” or “NO” whether the above-named individual has been experiencing any of the following conditions:***  1. Productive unexplained cough lasting longer than 2-3 weeks **YES\_\_\_ NO\_\_\_**  2.Pain in Chest  3.. Persistent weight loss without dieting **YES\_\_\_ NO\_\_\_**  4. Unexplained weakness or fatigue  5. Persistent low-grade fever (99°F - 101° F) **YES\_\_\_ NO\_\_\_**  (not associated with acute disease)  6. Excessive night sweats **YES\_\_\_ NO\_\_\_**  7. Loss of appetite **YES\_\_\_ NO\_\_\_**  8. Coughing up blood or sputum **YES\_\_\_ NO\_\_\_**  (phlegm from deep in lungs) | |
| **Staff Signature:** | **Date:** |
| ***For Use By Human Resources:***   1. Date Received: **\_\_\_\_\_\_\_\_\_\_\_\_\_** 2. If all answers are “No” - File in employee file 3. If one or more answers are “Yes” schedule employee for an appointment at the Health Department to determine if TB test or Chest X-Ray needs to be administered. 4. Date sent for TB Test\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. 5. Response from TB Test \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Attach copy of TB Test/X-Ray to form if administered.* | |
| ***For more information, please visit the Centers for Disease Control and Prevention:***  [***https://www.cdc.gov/tb/default.htm***](https://www.cdc.gov/tb/default.htm) | |