MY HOME CARE
"Keeping You at Home"

Annual TB Screening Questionnaire

1. Have you experienced any of the following symptoms in the past year?
   a) A productive cough for more than 3 weeks ☐ Yes ☐ No
   b) Coughing up blood ☐ Yes ☐ No
   c) Unexplained weight loss ☐ Yes ☐ No
   d) Fever, chills or night sweats for no known reason ☐ Yes ☐ No
   e) Persistent Shortness of breath ☐ Yes ☐ No
   f) Unexplained fatigue ☐ Yes ☐ No
   g) Chest Pain ☐ Yes ☐ No

2. Have you had contact with anyone with active TB disease in past year? ☐ Yes ☐ No
3. Do you have a medical condition, or are you taking any medication which suppress your immune system ☐ Yes ☐ No

Signature_____ Date_____

Revised: 7/03/2018
dr