



Tuberculosis (TB) Screening Questionnaire

Patient Name _____

	Please Check One	
	Yes	No
Have you been sick with a cough for more than two weeks?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had contact with anyone with Tuberculosis or Consumption?	<input type="checkbox"/>	<input type="checkbox"/>
Have you yourself ever had Tuberculosis or Consumption?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have night sweats?	<input type="checkbox"/>	<input type="checkbox"/>
Do you cough up blood?	<input type="checkbox"/>	<input type="checkbox"/>
Have you lost weight recently for no reason?	<input type="checkbox"/>	<input type="checkbox"/>

Time: _____ Date: _____

Signature: _____ Department _____

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Following Section to be completed by HealthWorks staff:

If patient answer YES to two or more questions, please complete the following:

	Please Check One	
	Yes	No
Physician notified: Name: _____ Time: _____	<input type="checkbox"/>	<input type="checkbox"/>
Patient given a mask?	<input type="checkbox"/>	<input type="checkbox"/>
Patient removed from general waiting area and placed in a private room?	<input type="checkbox"/>	<input type="checkbox"/>
Patient further evaluate?	<input type="checkbox"/>	<input type="checkbox"/>

Signature: _____

