I & Y Senior Care

EMPLOYEE ANNUAL TB QUESTIONNAIRE

Name:	Marital Status: ☐ M ☐ S ☐ W ☐ D	Sex: ☐ M ☐ F
Address:	DOB:	Title:
Emergency Contact:	Relationship:	
Emergency Address:	Telephone #:	

INDICATE ILLNESS EXPERIENCED BY YOU			HAVE YOU HAD ANY ILLNESS BELOW SINCE LAST ASSESSMENT		
CONDITION	YES	NO	CONDITION	YES	NO
DIABETES			MIGRAINE HEADACHES		
KIDNEY DISEASE			FAINTING OR DIZZINESS		
HEART DISEASE			WEIGHT GAIN/LOSS 15+LBS OR MORE		
HIGH BLOOD PRESSURE			CHANGE IN ENERGY LEVEL		
ARTHRITIS			FREQUENT COUGH		
TUBERCULOSIS			BLOOD IN SPUTUM		
MENTAL ILLNESS			SHORTNESS OF BREATH		
EPILEPSY/CONVULSIONS			CHEST PAIN/PRESSURE IN CHEST		
CANCER			SWELLING IN LEGS/FEET		
			PAIN IN CALF WHEN WALKING		
ARE YOU CURRENTLY:			CHANGE IN BOWEL HABITS		
ON LONG TERM STEROID THERAPY			BACK PAIN		
ON CHEMOTHERAPY			PAIN WHEN URINATING OR BLOOD IN URINE		
IMMUNO SUPPRESSED			HIGH BLOOD PRESSURE		
			INFECTIOUS DISEASE		
HISTORY			INCREASED THIRST		
COVID-19			PERSISTANT SORES OR LUMPS		

LIST ALL PRESCRIPTION MEDICATIONS TAKEN BY YOU:

Have you ever received a BCG Vaccine: ☐ No ☐ Yes **LAST CHEST X-RAY** ____/____/____
Have you converted to a positive PPD: ☐ No ☐ Yes **Date:** ___/___/___

Have you ever received treatment for TB? : ☐ No ☐ Yes When was this? _____
What medications did you take? _____

Have you traveled or lived outside the USA in the past year?: ☐ No ☐ Yes
If yes, where? _____

Are you experiencing any of the following:

Ongoing night sweats:	☐ No	☐ Yes	Chronic Fatigue:	☐ No	☐ Yes
Unexplained weight loss:	☐ No	☐ Yes	Persistent Cough > 3 wks:	☐ No	☐ Yes
Hoarseness:	☐ No	☐ Yes	Persistent fever:	☐ No	☐ Yes
Coughing up Blood:	☐ No	☐ Yes	Shortness of Breath:	☐ No	☐ Yes

If yes to any of the questions above, are you under treatment? ☐ No ☐ Yes With whom _____
Diagnosis: _____

Have you had the Flu Vaccine this season? ☐ Yes **Date of Vaccination/Proof attached:** _____
☐ No **Reason:** _____
If not, did you sign the declination form? ☐ Yes
☐ No

Name of your physician **Telephone #:**

Practitioner/RN Signature: _____ **Date:** _____

I declare that my answers and statements are correctly recorded, complete, and true to the best of my knowledge.
I have read the above and declare that I have no injury, illness or ailment other than as specifically identified that may interfere with the performance of my job responsibilities. I certify that I am not habituated or addicted to any depressants, stimulants, narcotics, drugs, alcohol or other substances that may alter my behavior.

Signature: **Date:**