ANNUAL TB SCREENING FORM

Name: _____

Social Security Number: _____

Have you ever had tuberculosis? Yes __ No __

If yes, please explain, including date of positive test, circumstances and treatment involved.

_____
_____
_____

Have you ever had the BCG vaccine? Yes ___ No____
Year received _____

Have you ever had a positive TB skin test? Yes ___ No ____
Date of the positive test: _____

If you were treated please include the dates treated and type of treatment:

_____
_____
_____
_____

Do you currently have any of the following symptoms?

- Productive or persistent cough (over 2 weeks duration) Yes ___ No ___
- Night sweats Yes ___ No ___
- Fever Yes ___ No ___
- Weight loss Yes ___ No ___
- Loss of Appetite Yes ___ No ___

Unless you provide documentation of positive test, the PPD test must be repeated. This is mandated by the Illinois Department of Public Health.

Signature: _____ Date: _____

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