Annual TB Screening

NAME: ____

Have you any previously known positive reaction or history of tuberculosis? ❒ **Yes** ❒ **No**

If yes, the result of at least one **Chest X-Ray** is required on file. Please **submit a copy** of the Chest X-Ray results and complete *Annual TB Questionnaire* form below. If No, complete the Mantoux Testing Record table.

Chest X-ray:

Date:_______________ Results: ____________________________________

Previous chest X-ray completed and on file? ❒ Yes ❒ No If yes, indicate date:_______________

Comments:____

TB Questionnaire

Please complete this form *annually* if you have tested positive for TB. If you answer "Yes" to any of the questions listed below, please explain under the "Comments" section. *Sign and date the bottom of the page*.

Yes	**No**	**Question**	**Comments**
		Cough or cold that won't go away?	
		Unexplained weight loss?	
		Night sweats?	
		Fever of unknown origin?	
		Shortness of breath?	
		Productive cough?	
		Bloody sputum?	

Mantoux Testing Record

Date Given	***Given By***	***Site***	***Date Read***	***Reaction in mm***	***Read By***

Employee Signature:______________________________ Date:_______________