

Annual TB Symptoms Evaluation

You can type your information directly into this form. You will not be able to save; print before closing.

Please check one:

- Previous positive TB skin test - positive reactor
- Immunosuppressive/other therapy contraindicating tuberculin skin testing
- Allergy to phenol
- BCG immunization*
- History of TB disease Date(s) _____
Treatment _____

Healthcare providers with a documented history of a positive TB skin test or who are unable to complete TB skin testing due to medical contraindications are required to complete an evaluation for symptoms of TB in lieu of an annual chest x-ray. Below is a list of symptoms frequently associated with TB disease. Please review the list and indicate any symptoms you may currently have, or have had, in the past 12 months by placing a check mark next to all that apply to you.

Please check

| Yes | No | | Yes | No | |
|-----------------------|-----------------------|---|-----------------------|-----------------------|--|
| <input type="radio"/> | <input type="radio"/> | Unexplained hoarseness | <input type="radio"/> | <input type="radio"/> | Coughing up blood (hemoptysis) |
| <input type="radio"/> | <input type="radio"/> | Loss of appetite | <input type="radio"/> | <input type="radio"/> | Recurrent shortness of breath |
| <input type="radio"/> | <input type="radio"/> | Unexplained weight loss | <input type="radio"/> | <input type="radio"/> | Unexplained fatigue or weakness |
| <input type="radio"/> | <input type="radio"/> | Productive or prolonged cough (over 2 weeks duration) | <input type="radio"/> | <input type="radio"/> | Chest pain |
| <input type="radio"/> | <input type="radio"/> | Bloody sputum | <input type="radio"/> | <input type="radio"/> | Recurrent pneumonia |
| <input type="radio"/> | <input type="radio"/> | Persistent fever (over 100 F | <input type="radio"/> | <input type="radio"/> | Unprotected exposure to a known TB patient Date of exposure _____ |
| <input type="radio"/> | <input type="radio"/> | Night sweats | <input type="radio"/> | <input type="radio"/> | Present symptoms experienced |

If at any time during the 12-month period between TB screens you experience symptoms of potential TB, please immediately notify the Employee Health/Infection Prevention Department.

Healthcare Provider (print name)

Healthcare Provider Signature

Date

Witness Signature

Witness Title

Date

HEALTH PROFESSIONALS

This form was created by the American Lung Association in Indiana with the assistance of our Tuberculosis Quality Task Force. For more information, visit us at **LungIN.org** (click on Programs and Materials, select Tuberculosis). We offer one of the best TB education programs in the country. Our TB program is approved by the American Lung Association, the Indiana State Department of Health and the Centers for Disease Control.

If you have medical-related TB questions, consult with your organization's policies or contact the Indiana State Department of Health TB Department at **317-233-7434**.

*False positive reactions may occur with TB skin testing following BCG vaccination; however, reactions tend to wane five or more years after immunization. If TB skin testing results in a positive reaction, it is recommended that a blood assay for Mycobacterium Tuberculosis be obtained.