Tuberculosis (TB) Screening Questionnaire

**Please complete the following questions**

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| 1) Have you been treated for active TB? | **□** | **□** |
| 2) Have you been treated for latent TB? | **□** | **□** |
| 3) Have you received the BCG vaccine? | **□** | **□** |
| 4) Have you had contact with any person with known active TB? | **□** | **□** |
| 5) Symptoms of active TB |  |  |
| Please indicate whether you are experiencing any of the following symptoms: | | |

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| ① Persistent cough that lasts 2 – 3 weeks or longer | **□** | **□** |
| ② Coughing up blood | **□** | **□** |
| ③ Unexplained weight loss | **□** | **□** |
| ④ Night sweats | **□** | **□** |
| ⑤ Persistent fever | **□** | **□** |
| ⑥ Weakness or fatigue | **□** | **□** |