ATTACHMENT 4
TUBERCULOSIS SCREENING QUESTIONNAIRE

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Agency Health Provider Name

HX of Positive TB skin test (PPD)? **Yes** ☐ **or No** ☐ **Date:** _____

HX of BCG Exposure **Yes** ☐ **or No** ☐ **Date:** _____

Hx of Allergy to TB Test **Yes** ☐ **or No** ☐ **Date:** _____

Last Chest x-Ray date: ______________________________

Please indicate if you have had any of the following problems for Three (3) weeks or longer:

		Yes	No
1.	**Chronic Cough (Greater than 3 weeks)**	☐	☐
2.	**Production of Sputum**	☐	☐
3.	**Blood Streaked Sputum**	☐	☐
4.	**Unexplained Weight Loss**	☐	☐
5.	**Fever**	☐	☐
6.	**Fatigue/Tiredness**	☐	☐
7.	**Night Sweats**	☐	☐
8.	**Shortness of Breath**	☐	☐

NO EVIDENCE OF PULMONARY TUBERCULOSIS OR CONTAGIUM

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Date **Agency Health Provider Signature**

Physician Name
& Address printed
(or stamp)

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Date **Physician's Signature**

(Arizona Administrative Code, Amendment R9-10-206, Section 3(b))

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