ATTACHMENT 4
TUBERCULOSIS SCREENING QUESTIONNAIRE

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:

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

NO EVIDENCE OF PULMONARY TUBERCULOSIS OR CONTAGIUM

Date **Agency Health Provider Signature**

Physician Name & Address printed (or stamp) _____

_____

_____

Date **Physician's Signature**

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

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