TB TARGETED MEDICAL QUESTIONNAIRE AND RISK FORM

_____
Employee Printed Name

1. Have you ever had a positive TB skin test or history of TB infection? ____
   If the answer is YES, please answer the following:
2. Have you ever had the BCG vaccine? ____
3. Do you have prolonged or recurrent fever? ____
4. Have you recently lost weight? ____
5. Do you have a chronic cough? ____
6. Do you cough up blood? ____
7. Do you have sweating at night? ____
8. Do you have any of the following risk factors?
   - ____ a. Silicosis (Lung Disease)
   - ____ b. Gastrectomy
   - ____ c. Intestinal Bypass
   - ____ d. Weight 10% or more below ideal body weight
   - ____ e. Chronic Renal Disease
   - ____ f. Diabetes Mellitus
   - ____ g. Prolonged high-dose corticosteroid therapy or other Immunosuppressive therapy
   - ____ h. Hematologic Disorder i.e. leukemia or lymphoma
   - ____ i. Exposure to HIV or AIDS
   - ____ j. Other malignancies

Baseline Individual TB Risk Assessment

Answer "Yes" or "No". Employee should be considered at risk for TB if any of the following statements are marked "Yes".

_____ Temporary or permanent residence of ≥ 1 month in a country with a high TB rate (any country other than the U.S., Canada, Australia, New Zealand, and those in Northern or Western Europe)

_____ Current or planned immunosuppression, including HIV infection, organ transplant recipient, treatment with a TNF alpha antagonist, chronic steroids, or other immunosuppressive medication.

_____ Close contact with someone who has had infectious TB disease since the last TB test

_____ _____
Employee Signature Date

_____ _____
Reviewed by Signature Date