

**Montana Mental Health Nursing Care Center
TB Screening Questionnaire
CONFIDENTIAL**

_____/_____/_____
Last Name First Name Middle Initial Date Form Completed

1. Do you have a history of a Positive Tuberculin Skin Test? Yes No

2. What is your current job title? _____

3. Where in the facility do you spend most of your work day? _____

4. Since your last TB review, have you worked in a location where patients with active TB received care or services?

 Yes No Don't know

5. Since your last TB review, have you lived with or had close contact with someone who has TB disease?

 Yes No Don't know

6. Since your last TB review, have you had an abnormal chest x-ray?

 Yes No Don't know

7. Since your last TB review, has a health practitioner told you that your immune system isn't working right or can't fight infection?

 Yes No Don't know

8. Do you work, volunteer, or live in another facility that provides medical or social services?

 Yes No Don't know

9. Since your last TB review, have you traveled outside the U.S.A.?

 Yes No Don't know If yes, Where? _____

10. Since your last TB review, have you had any of the following symptoms for more that 3 weeks at a time? *(Please check all that apply)* Yes No

 Persistent coughing Excessive fatigue Coughing up blood
 Hoarseness Excessive sweating at night Persistent fever
 Excessive weight loss