LAKESHORE

*Home Health Care Services, Inc.*



**TUBERCULOSIS QUESTIONNAIRE**

**HAVE YOU NOTICED ANY OF THE FOLLOWING?**

**(Circle one)**

**Unexplained Fevers Yes No**

**Night Sweats Yes No**

**Unintentional weight loss Yes No**

**Cough Yes No**

**Hoarseness Yes No**

**Bloody Sputum Yes No**

**Have you completed INH therapy? Yes No**

**Have you ever had a BCG vaccine? Yes No**

**Have you had an x-ray while employed here? Yes No**

**Employee Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Follow-up needed \_\_\_ Yes \_\_\_No**

**Comments:**

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# Agency Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revised 1/15/2014