TB SCREENING

DOD [illegible]

James Winsor
Employee

Dining Services
Department

8.4.13 2115 (L) forearm [illegible] 30861FO
1) Date TB Test Administered Lot # exp 1.16

8/6/13 – Negative – WB.
Results & Date Results Read

X X X X X X X X X
2) Date TB Test Administered Lot #

X X X X X X X X X
Results & Date Results Read

1. Have you ever received a TB test? **Yes** No
   Year yearly Reaction neg.

2. Have you ever had a severe reaction to TB test? Yes **No**

3. Have you ever received BCG? Yes **No**
   If YES, when?______________

4. Have you ever had preventive therapy for a positive TB test? Yes **No**
   If YES, when?____________ Treatment given____________________

5. Have you ever had tuberculosis? Yes **No**
   If YES, when?__________

6. Have you ever had treatment for tuberculosis? Yes **No**
   If YES, when?________ Treatment given______________How long?________

7. Have you ever had a chest x-ray for a positive TB test? Yes **No**
   If YES, date of last X-ray____________________

8. Do you have or have you experienced any of the following symptoms?
   a. Unexplained loss of appetite Yes **No**
   b. Night sweats Yes **No**
   c. Fatigue, malaise Yes **No**
   d. Unexplained weight loss Yes **No**
   e. Cough, productive or nonproductive, of 3 weeks or more? Yes **No**
   f. Unexplained fever Yes **No**
   g. Coughing up blood Yes **No**

If YES to any of the above, explain further:______________________________

NOTE: I understand that due to my occupation I may be at risk of acquiring tuberculosis. If at any time I begin to experience the above symptoms on a persistent basis, I am aware that I should promptly contact the Resident Health Department so that testing can be done to determine the presence of disease.

Employee Signature [signature] Date________________

Screened by: [signature] Date 8.4.13
Print name

Screened by [signature], RN – 8/6/13
Signature

Is medical follow-up necessary?	Yes________	No X

June 2004
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