ANNUAL TUBERCULOSIS SURVEILLANCE QUESTIONNAIRE

This form is to be used for those with a previous positive Tuberculosis Skin Test result. Please answer the following questions and return this form to Chesapeake Home Health Care, Inc. within **1 week** of receiving this questionnaire. **This form may be faxed or mailed**.

Have you EVER had a POSITIVE TB skin test? (Circle) **YES** **NO**
(If "NO," stop here; if "YES," Please complete the rest of this form.)

Question		
Were you born in the United States? If no, identify country you were born in: ______________________________		
Have you ever traveled outside the United States in the past 12 months? If Yes, identify city, country, and approximate month:		
Have you ever been told by a Doctor or other health care provider that you had active TB?		
Have you ever worked where patients with active tuberculosis disease receive care or services?		
Have you ever lived with or had close contact with someone who has/had active tuberculosis disease?		
Have you ever worked, volunteered, or lived in any institution such as a jail, group home, or homeless shelter in the past year (12 months)?		
Have you had pneumonia in the past year?		
Has a Doctor or other health care provider ever told you that your immune system is not working right or that you cannot fight infection in the past year?		

In the past 12 months, have you had any of the following symptoms (please check all that apply)**:**

[ ] Persistent Coughing
[ ] Excessive Fatigue
[ ] Coughing up Blood
[ ] Hoarseness
[ ] Excessive Sweating at Night
[ ] Persistent Fever
[ ] Excessive Weight Loss

Should any of these symptoms develop within the year, please notify the Agency (your RN supervisor) and alert your regular physician of your symptoms/positive skin test.

Nurse Name: ______________________________

Nurse Signature: ______________________________ Date: ____________

Authorized Healthcare Provider: ______________________________ Date: ____________

DON Signature: ______________________________ Date: ____________