SANILAC COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

# ANNUAL TUBERCULOSIS HEALTH QUESTIONNAIRE

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| Staff Name:  |
| *This form must be completed & returned to Human Resources* |
| ***Please indicate by checking “YES” or “NO” whether the above-named individual has been experiencing any of the following conditions that are not associated with a known illness***1. Productive unexplained cough lasting longer than 3 weeks **YES\_\_\_ NO\_\_\_** 2.Pain in Chest3.. Persistent weight loss without dieting **YES\_\_\_ NO\_\_\_**4. Unexplained weakness or fatigue5. Persistent low-grade fever (99°F - 101° F) **YES\_\_\_ NO\_\_\_** (not associated with acute disease)6. Chills **YES\_\_\_\_ NO\_\_\_\_**6. Excessive night sweats **YES\_\_\_ NO\_\_\_**7. Loss of appetite **YES\_\_\_ NO\_\_\_**8. Coughing up blood or sputum **YES\_\_\_ NO\_\_\_**(phlegm from deep in lungs)***Staff are able to request a TB test in lieu of completing this questionnaire, per policy BA160, Tuberculosis (TB/Hepatitis B (Hep B)***  |
| **Staff Signature:** | **Date:** |
| ***For Use By Human Resources:***1. Date Received: **\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. If all answers are “No” - File in employee file
3. If one or more answers are “Yes” schedule employee for an appointment at the Health Department to determine if TB test or Chest X-Ray needs to be administered.
4. Date sent for TB Test\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
5. Response from TB Test \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| ***For more information, please visit the Centers for Disease Control and Prevention:***[***https://www.cdc.gov/tb/?CDC\_AAref\_Val=https://www.cdc.gov/tb/default.htm***](https://www.cdc.gov/tb/?CDC_AAref_Val=https://www.cdc.gov/tb/default.htm) |