



## TB SURVEILLANCE SYMPTOM REVIEW FOR +PPD EMPLOYEES

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

1. Have you ever been treated for a +PPD with INH?  Yes  No

If Yes, when? \_\_\_\_\_

2. Have you had any known exposure to TB? \_\_\_\_\_

3. Have you ever received BCG?  Yes  No If yes, where and when? \_\_\_\_\_

3. Have you been bothered during the past year by any of the following?

a. Night Sweats  Yes  No

b. Persistent Coughing  Yes  No

c. Coughing up blood  Yes  No

d. Excessive weight loss  Yes  No

e. Excessive fatigue or tiredness  Yes  No

f. Fever of unknown origin  Yes  No

EMPLOYEE'S SIGNATURE: \_\_\_\_\_

REVIEWED BY: \_\_\_\_\_