Mid Michigan Community College

TB Screening Questionnaire

If you have had a positive TB skin test in the past it is important that you promptly report pulmonary symptoms to your physician.

Name ____ Date of Birth: ______________________

Please review the list of symptoms below and check “yes” or “No” in the appropriate box stating you do or do not have that symptom.

	Yes	No	Year
1. Have you ever had a Positive TB test?			
2. Have you ever had a cough with bloody sputum (phlegm) for three weeks or longer?			
3. Have you experienced unexplained fever, weight loss or night sweats for two weeks or longer?			
4. Have you been told that you have TB or been treated for TB in the past five years?			
5. Are you currently pregnant/breastfeeding?			
6. Have you been exposed to anyone with known TB?			
7. Do you have a loss of appetite?			
8. Have you experienced shortness of breath or chest pain?			
9. Do you have swollen glands (usually in the neck)?			

Signature ____ Date ______________