



Occupational Health

BMCHS Occupational Health
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TB Risk & Symptom Screen Form

LAST NAME	FIRST NAME	MIDDLE NAME
DATE OF BIRTH	PHONE NUMBER	HOME <input type="checkbox"/> CELL <input type="checkbox"/>
EMPLOYER	POSITION	EMP ID#
		WORK EMAIL

TB Risk Assessment

	YES	NO
Have you had a positive reaction to a TB test? ▪ If so, when: _____ ▪ Have you taken medication for a positive TB test? <input type="checkbox"/> Yes <input type="checkbox"/> No ▪ If so, for how long: _____		
Were you born outside of the United States? ▪ If so, where: _____ Date of entry into US: _____		
Have you traveled outside of the country for 30 days or more? ▪ If so, where: _____		
Have you had close contact with someone who has had active TB?		
Do you have any condition or take medication that can affect your immune system? ▪ Examples: HIV, organ transplant recipient, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone) or other immunosuppressive medication		

TB Symptom Screening

	YES	NO
Have you had a bad cough lasting 3 weeks or longer?		
Do you cough up sputum?		
Do you cough up blood?		
Experienced unintentional weight loss > 10 pounds?		
Have you experienced any loss of appetite?		
Do you become tired easily without apparent reason?		
Have you experienced night sweats?		
Have you experienced a fever for more than two weeks?		