

Sample Annual Tuberculosis (TB) Risk Assessment Questionnaire for Employees



Last name	First name	MI
Address	City	State
Phone	Email	Zip
Date of Birth	Country of Birth	

1. Have you traveled outside the U.S. since your last risk assessment? No Yes

If yes, list countries, duration of visits, and purpose of travel

2. Have you been diagnosed with any of the following conditions that may impair your immune system?

No Yes

Chronic steroid use	Gastrectomy/intestinal bypass	Diabetes mellitus
HIV infection	Crohn's disease	Dialysis/Renal failure
Cancer of the head or neck	Rheumatoid arthritis	Chronic malabsorption syndromes
Silicosis	Use of TNF- α antagonist	Low body weight (10% or more below ideal)
Leukemia, lymphoma or Hodgkin's disease		

3. Have you ever resided, worked or volunteered in any of the following facilities?

No Yes If yes, check all that apply

Prison	Hospital	Nursing home
Homeless shelter	Other long term treatment center	

4. Do you currently have any of the following symptoms? No Yes If yes, check all that apply

Cough \geq 3 weeks	Unexplained fever	Chest pain	Chills
Productive cough (coughing something)	Night sweats	Respiratory difficulty (shortness of breath)	Loss of appetite
Coughing up blood	Unexplained weight loss	Fatigue	Weakness

5. Have you ever had contact with a person known to have active tuberculosis? No Yes

6. Have you ever had an abnormal chest X-ray? No Yes

8. Have you had a tuberculin skin test or IGRA blood test before? Yes No

If yes, list where given Date

If yes, provide documentation (attach results)

9. If the test result was positive, did you take TB medications? No Yes

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a. If you took TB medication(s), what did you take?

Name of TB medication Don't know

b. Where were you treated?
(city, state, country, doctor's contact information)

c. What year did you start treatment?

d. How long did you take this medication?

The information above is true and complete to the best of my knowledge, and I am aware that deliberate misrepresentation may jeopardize my health. I understand that this information is confidential and will not be released without my knowledge and written permission.

Printed name

Employee signature

Date

FOR INTERNAL USE ONLY

Name of sender	Title
Facility name	
Phone number	Secure Fax
Address	State Zip
Sender signature	Date referral sent

Referred to:	
<input type="checkbox"/> PCP <input type="checkbox"/> Urgent Care <input type="checkbox"/> ED <input type="checkbox"/> Employee Health <input type="checkbox"/> Other	
Name of person/facility	
Address	
<input type="checkbox"/> Fax	<input type="checkbox"/> phone call
Reason for Referral	
Requested follow-up	
<input type="checkbox"/> TST/PPD <input type="checkbox"/> IGRA <input type="checkbox"/> CXR <input type="checkbox"/> CT <input type="checkbox"/> Medical Evaluation <input type="checkbox"/> 3 Sputum for Acid Fast Bacilli	
<input type="checkbox"/> Other	