



PPD Questionnaire

YEARLY QUESTIONNAIRE FOR INDIVIDUALS WITH POSITIVE TUBERCULIN SKIN TESTS

NAME (please print): _____

DATE OF POSITIVE PPD EXAM: _____

DATE OF BCG VACCINATION: _____

During the past year have you experienced any of the following signs or symptoms: Please circle the appropriate response:

Unexplained Persistent Cough:	YES	NO
Coughing Up Blood:	YES	NO
Unexplained Significant Weight Loss/Anorexia:	YES	NO
Unexplained Persistent Fever:	YES	NO
Night Sweats:	YES	NO
Unexplained Fatigue:	YES	NO
Unexplained Chest Pain:	YES	NO

I understand the importance of seeking medical attention from my physician if I display any of the above signs or symptoms of TB. I will also notify my physician & *Onward Healthcare* of any exposure to Tuberculosis.

Signature

Date