



PPD Questionnaire

A 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 below.*

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Unexplained Persistent Cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughing Up Blood |
| <input type="checkbox"/> | <input type="checkbox"/> | Unexplained Significant Weight Loss/Anorexia |
| <input type="checkbox"/> | <input type="checkbox"/> | Unexplained Persistent Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Night Sweats |
| <input type="checkbox"/> | <input type="checkbox"/> | Unexplained Fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | Unexplained Chest Pain |

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.

Employee Signature: _____

Date: _____