MARQUIS HOME CARE

230 N. Main Street, Spring Valley, NY 10977 Phone: (845) 363-8140 Fax: (845) 363-8141

Employee Name: _____

ANNUAL TUBERCULOSIS QUESTIONNAIRE

For personnel who have a known positive PPD or whole blood assay are required to complete this questionnaire with either a yes or no.

HAVE YOU NOTICED ANY OF THE FOLLOWING?

1. Unexplained fevers	☐ **Yes** ☐ **No**
2. Night Sweats	☐ **Yes** ☐ **No**
3. Unintentional weight loss	☐ **Yes** ☐ **No**
4. Cough	☐ **Yes** ☐ **No**
5. Hoarseness	☐ **Yes** ☐ **No**
6. Bloody Sputum	☐ **Yes** ☐ **No**
7. Have you completed INH therapy?	☐ **Yes** ☐ **No** If Y, Date of Completion :_____
8. Have you ever had a BCG vaccine?	☐ **Yes** ☐ **No**
9. Have you had an x-ray while employed here?	☐ **Yes** ☐ **No**

_____ _____

Employee Signature ***Date***

For Office Use:

Follow-up needed ___ Yes ___No

Comments: _____

_____

_____

_____

Agency Representative: _____ ***Date***_____