**SCOTLAND HEALTHCARE SYSTEM**
**EMPLOYEE HEALTH SERVICES**
**RECORD OF TUBERCULOSIS SCREENING**

**Name:** ____________________________________________________________

**Date of Birth:** ___/___/___ **Department:** ________________________________

**Date of Last Chest X-Ray:** ______________

**Please answer the following questions:**
**TB Risk Questionnaire: Check Yes or No**

1. Were you born outside the USA in one of the following parts of the World: Africa, Asia, Central America, South America, or Eastern Europe? ☐ Yes ☐ No
2. Have you traveled outside the USA and lived for more than one month in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe? ☐ Yes ☐ No
3. Do you have a compromised immune system such as from any of the following conditions: HIV/AIDS, organ or bone marrow transplantation, diabetes, immunosuppressive medicines (e.g. prednisone, Remicade), leukemia, lymphomas, cancer of the head or neck, gastrectomy or jejeunal bypass, end-stage renal disease (on dialysis), or silicosis? ☐ Yes ☐ No
4. Have you ever done one of the following: used crack cocaine, injected illegal drugs, worked or resided in jail or prison, worked or resided at a homeless shelter, or worked as a healthcare worker in direct contact with patients? ☐ Yes ☐ No

**TB Symptom Questionnaire**
**Please answer the following questions. Do you currently have any of the following symptoms?**

1. Unexplained cough lasting more than 3 weeks? ☐ Yes ☐ No
2. Unexplained weight loss? ☐ Yes ☐ No
3. Unexplained appetite loss? ☐ Yes ☐ No
4. Unexplained fever? ☐ Yes ☐ No
5. Night sweats ☐ Yes ☐ No
6. Shortness of breath? ☐ Yes ☐ No
7. Chest pain? ☐ Yes ☐ No
8. Unexplained fatigue? ☐ Yes ☐ No

**The above health statement is accurate to the best of my knowledge. I will notify Employee Health and see my MD and/or local Health Department if my health status changes.**

______________________________
**Print Name**

______________________________ ____________________
**Signature** **Date**