TB Screening Questionnaire

☐ Campus ☐ Highlands ☐ Hospital ☐ HSF/TKC ☐ School of Medicine ☐ International Visitor

Name: _____

Date: _____Date of Birth: _____ Last 4 SSN: _____

Contact Number: _____

Instructions: Please answer the following questions truthfully. Please check the appropriate answers:

		YES	NO
1)	Have you experienced any of the following symptoms **within the past year**?		
	a. Persistent productive cough (3 weeks or longer)?	☐	☐
	b. Coughing up blood?	☐	☐
	c. Chest pain?	☐	☐
	d. Shortness of breath/difficulty breathing?	☐	☐
	e. Unexplained fever lasting more than 3 days?	☐	☐
	f. Unexplained night sweats?	☐	☐
	g. Unexplained, sudden weight loss?	☐	☐
	h. Unexplained fatigue/run down feeling?	☐	☐
	i. Unexplained swollen lymph nodes or masses in your armpit or neck area?	☐	☐
2)	Have you ever…		
	a. Lived or been in close contact with someone who had tuberculosis disease?	☐	☐
	b. Had a positive tuberculosis skin test?	☐	☐
	c. Been diagnosed with or treated for tuberculosis?	☐	☐
	d. Taken the BCG vaccine?	☐	☐
	e. Considering the list of countries below:		
	i. **Africa**		
	ii. **Asia**: China, Mongolia, Vietnam, Korea, Indonesia, India, Pakistan and Bangladesh		
	iii. **Eastern Europe**: Russia and former Soviet Union States, Armenia		
	iv. **Latin America**: Mexico, Guatemala, South America		
	v. **Caribbean Islands**: Jamaica, Dominican Republic, Haiti, Cuba, Trinidad and Tobago		
	vi. **Pacific Islands**: including the Philippines, excluding Hawaii		
	a) Resided in a country with high incidence of tuberculosis for one month or longer?	☐	☐
	b) Been a resident and/or employee of a high risk congregate setting (example: correctional facilities, long-term care facilities, homeless shelters)?	☐	☐

c) Been a volunteer or health care worker who served clients who are at increased risk for tuberculosis? . . . . . ☐ ☐

3) Will you be visiting a patient care area while at UAB (Hospital, Clinic, School of Medicine, School of Dentistry, School of Nursing, School of Optometry, etc.) ***AND*** be visiting UAB for more than 30 days?. ☐ ☐

I certify that the information contained on this TB Screening Form is true and correct. I hereby understand that if any of the above responses are "Yes", I will be re-evaluated by UAB Employee Health to rule out the presence of active tuberculosis. Furthermore, I may be required to have further TB testing to obtain clearance from UAB Employee Health.

Signature: _____

Date: _____

Form submittal:

For Campus employees and International Visitors, you may submit completed form electronically to ehocchealth@uab.edu.

For Highlands, Hospital, HSF and TKC, you may submit completed form electronically to employeehealth@uabmc.edu.