



FASTAFF Travel Nursing
Tuberculosis Screening Questionnaire

Name

Date

Positive TB skin test (PPD) Date: _____

Last Chest X-Ray Date: _____

Please indicate if you are having any of the following problems for three to four weeks or longer:

- 1. Chronic Cough (greater than 3 weeks) Yes _____ No _____
- 2. Production of Sputum Yes _____ No _____
- 3. Blood-Streaked Sputum Yes _____ No _____
- 4. Unexplained Weight Loss Yes _____ No _____
- 5. Fever Yes _____ No _____
- 6. Fatigue/Tiredness Yes _____ No _____
- 7. Night Sweats Yes _____ No _____
- 8. Shortness of Breath Yes _____ No _____

Date

Employee Signature