



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 Agency

\_\_\_\_\_  
Employee Signature