ANNUAL TUBERCULOSIS SCREENING ASSESSMENT

The Caregiver is required to complete and return this form

Please use care and accuracy in answering all questions

NAME: _____

1. Do you currently have any of the following symptoms?

SYMPTOMS	YES	NO	COMMENTS
Weakness			
Fatigue			
Lack of Appetite			
Low Grade Fever			
Night Sweats			
Flu-like Symptoms			
Chest Pain			
Shortness of Breath			
Persistent Cough			
Blood Streaked Sputum			
Clear, Yellow or Dark Sputum			

2. Have you been exposed to anyone with the above signs or symptoms or who has had Tuberculosis? Yes _____ No _____
3. Have you traveled out of the country in the past year? Yes _____ No _____

If I should notice any of the above signs or symptoms, I will immediately notify my physician and EldersChoice.

_____ _____

Caregiver Date