CAROLINE COUNTY HEALTH DEPARTMENT

EMPLOYEE ANNUAL TB SYMPTOM

CHECKLIST

Employee Name _____

Department_____

Date_____

Please answer each question and return to Employee Health when complete.

1. Have you knowingly been exposed to TB in the past year?	Yes	No
2. Cough for more than 3 weeks?	Yes	No
3. Coughing up blood?	Yes	No
4. Unexplained fever?	Yes	No
5. Unexplained night Sweats?	Yes	No
6. Unexplained weight loss/poor appetite?	Yes	No
7. Chest pain or shortness of breath?	Yes	No
8. Unexplained tiredness?	Yes	No

I consent to the above screening. I understand if I should develop any of the above symptoms, I should consult with my primary care physician and Employee Health Program staff.

_____ _____

Employee Signature Date Nurse Signature Date

2/15 EW