

MEDCALL NORTHWEST
ANNUAL TUBERCULOSIS SURVEILLANCE FORM

NAME _____

1. Date of your last TB skin test _____

2. Date of your last chest x-ray _____

Were the results within normal limits? Yes No

a. Are you a known positive reactor to the tuberculin TB skin test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Have you had the BCG?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Have you ever received treatment for the tuberculosis bacillus?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Have you encountered an exposure to tuberculosis within the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. Are you experiencing any of the following signs or symptoms that would be consistent with a diagnosis of tuberculosis?		
• Night sweats	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Unexplained weight loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Bloody Sputum	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Lingered Upper Respiratory Infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please explain any "Yes" Statements:

Print Name

Signature

Date