Holsman Healthcare, LLC
Healthcare Staffing and Consulting Services
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Tuberculosis Screening Questionnaire

Any candidates who submit a chest x-ray as proof of their *Tuberculosis* screening due to a prior positive PPD must complete the following questionnaire on an annual basis. Please complete the information below and submit the completed form with documentation of the most recent chest x-ray.

Name: _____

Date (m/d/y) of positive PPD: _____/_____/_____ Date (m/d/y) of last chest x-ray: _____/_____/_____

Please indicate if you have had any of the following symptoms for three to four weeks or longer since your last chest x-ray:

• chronic cough	☐ YES	☐ NO
• unexplained productive cough	☐ YES	☐ NO
• production of sputum	☐ YES	☐ NO
• blood-streaked sputum	☐ YES	☐ NO
• unexplained appetite loss	☐ YES	☐ NO
• unexplained weight loss	☐ YES	☐ NO
• unexplained fever	☐ YES	☐ NO
• chest pains	☐ YES	☐ NO
• increased fatigue / tiredness	☐ YES	☐ NO
• persistent night sweats	☐ YES	☐ NO
• shortness of breath	☐ YES	☐ NO

The above health statement is true and accurate to the best of my knowledge and there is no evidence of pulmonary tuberculosis or contagion. I will visit my physician or a local health department if my health status should change.

_____ _____
Signature Date

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