



TUBERCULOSIS (TB) ANNUAL SCREENING QUESTIONNAIRE

AAAHC-Aligned Healthcare Personnel and Vendor Compliance Form

Employee / Vendor Information

Name: _____
Date of Birth: _____
Company: _____
Date Completed: _____

SECTION 1: TB SYMPTOM SCREENING

Question	YES	NO
Persistent cough > 3 weeks	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
Fever or chills	<input type="checkbox"/>	<input type="checkbox"/>
Unusual fatigue	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 2: TB EXPOSURE RISK

Question	YES	NO
Close contact with active TB case (past 12 months)	<input type="checkbox"/>	<input type="checkbox"/>
Travel to high TB prevalence area (past 12 months)	<input type="checkbox"/>	<input type="checkbox"/>
Work/residence in high-risk setting	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 3: MEDICAL RISK FACTORS

Question	YES	NO
----------	-----	----

Immunocompromised condition	<input type="checkbox"/>	<input type="checkbox"/>
Use of immunosuppressive medications	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 4: TB HISTORY

History of positive TB test: YES NO

If YES, date: _____

History of TB treatment: YES NO

Most recent TB test date: _____

SECTION 5: ATTESTATION

I certify the information provided is accurate. Any positive response may require further evaluation and TB testing prior to clearance.

Signature: _____

Date: _____

FOR ADMINISTRATIVE USE ONLY

Cleared for Work: YES NO

Additional Testing Required: YES NO

Reviewed By: _____

Date: _____