children'shealth

## ANNUAL TUBERCULOSIS/N95 MASK SCREENING

| Name | Date of Birth |
|---|---|
| Preferred Email Address | Preferred Phone Number |

| ☐ Employee | ☐ Medical Staff | ☐ Med Educ. | ☐ Volunteer | ☐ Other |
|---|---|---|---|---|
| CMC Employees including APN's<br><br>ID# _____ | Attending MD, Dental, Allied Health, Other<br><br>ID# _____ | Fellow, Resident, Rotating Resident, other<br>ID# _____ | Annual, 1st year, pastoral care, other<br><br>ID# _____ | Traveler, Other Title: _____<br><br>ID# _____ |

| **In the past year, have you:** | | |
|---|---|---|
| Had a known exposure to TB and were ***not*** wearing a mask | ☐ YES | ☐ NO |
| Diagnosis of Pneumocystis Carinii Pneumonia | ☐ YES | ☐ NO |
| Diagnosis of being immune compromised | ☐ YES | ☐ NO |
| Taking medications that are immunosuppressive | ☐ YES | ☐ NO |
| Cough lasting longer than three weeks | ☐ YES | ☐ NO |
| Loss of appetite | ☐ YES | ☐ NO |
| Unexplained weight loss | ☐ YES | ☐ NO |
| Profuse night sweats | ☐ YES | ☐ NO |
| Fatigue (unusual tiredness) | ☐ YES | ☐ NO |
| Coughing up blood | ☐ YES | ☐ NO |
| Chills and/or fever | ☐ YES | ☐ NO |
| Chest pain | ☐ YES | ☐ NO |
| Difficulty breathing | ☐ YES | ☐ NO |
| Traveled outside the United States | ☐ YES | ☐ NO |
| Volunteered in a homeless shelter or jail? | ☐ YES | ☐ NO |
| Had visitors from a foreign country stay with you | ☐ YES | ☐ NO |
| If you answered yes to any of the above, please explain. | | |
| Have you ever had a TB Test? | ☐ YES | ☐ NO |
| Have you ever had a positive TB Test? | ☐ YES | ☐ NO |
| If yes, please list date performed<br>☐ Skin Test _____ ☐Quantiferon Blood Test _____<br><br>Was a Chest X-ray completed and reviewed by a radiologist?<br>☐Date: _____ | | |
| **TB Respirator N95 Mask** (if yes, consider retesting) | | |
| Any changes in facial structure such as jaw surgery, facial hair, new eyeglasses, etc. | ☐ YES | ☐NO |
| Weight gain or loss of 15 pounds or more? | ☐ YES | ☐NO |

_____ _____

Your Signature Date

_____ _____

Occupational Health Nurse Date