400 N. Pepper Ave, Colton, CA 92324-0013 | Phone: 909.580.1701 Fax: 909.580.1359

www.SBCounty.gov

SAN BERNARDINO COUNTY

Human Resources
Center for Employee Health and Wellness

TUBERCULOSIS QUESTIONNAIRE

Name	Employee ID# or SSN	Today's Date
Department	Division	
Signature	Primary Phone	

Please answer all of the following questions

1. Were you born in, travelled to, or resided in a country with an elevated TB rate for at least one month or made frequent border crossings? *(Generally, any country other than the United States, Canada, Australia, New Zealand, Japan, and Northern/Western Europe.)* ☐ Yes ☐ No
2. Are you currently, or plan to be, immunosuppressed? *(HIV infection, organ transplant recipient, treated with biologic agents including TNF-alpha antagonist [e.g., infliximab, adalimumab, etanercept, others], steroids [equivalent of prednisone ≥15 mg/kg/day for ≥1 month] or other immunosuppressive medication.)* ☐ Yes ☐ No

3a. Have you been in close contact with someone with infectious TB in your lifetime? ☐ Yes ☐ No

3b. If yes, did this contact occur since your last TB test, if applicable? ☐ Yes ☐ No

4. Have you ever, or are you now experiencing homelessness or incarceration? ☐ Yes ☐ No

5. Have you ever had a **positive** TB test? *(CEHW only accepts TB documentation that is 90 days old or less.)* ☐ Yes ☐ No

6. Are you currently experiencing:
   - Unexplained weight loss in the last year? ☐ Yes ☐ No
   - Decrease in your appetite? ☐ Yes ☐ No
   - Increase in coughing other than that associated with a brief illness? (Other than cold or flu) ☐ Yes ☐ No
   - Color or consistency changes in, or increased production of your sputum/saliva? ☐ Yes ☐ No
   - Persistent unexplained fevers or night sweats? ☐ Yes ☐ No
   - Weakness or fatigue? ☐ Yes ☐ No
   - Abnormal chest x-ray consistent with TB disease? ☐ Yes ☐ No

If you answered yes to any questions, please explain:

Administration Record

1. Mantoux PPD Skin Test (5 t.u./0.1ml/dose)	Vial lot number	Expiration Date
Date PPD#1 Given / /	Given by	Site (Forearm) ☐ L ☐ R
Time given	☐ PH ☐ Other ☐ CEHW	Clinic Site
Date PPD#1 Read / /	Read by	Result mm/Induration
Time PPD#2 Read	☐ PH ☐ Other ☐ CEHW	Clinic Site

2. Mantoux PPD Skin Test (5 t.u./0.1ml/dose)	Vial lot number	Expiration Date
Date PPD#1 Given / /	Given by	Site (Forearm) ☐ L ☐ R
Time given	☐ PH ☐ Other ☐ CEHW	Clinic Site
Date PPD#1 Read / /	Read by	Result mm/Induration
Time PPD#2 Read	☐ PH ☐ Other ☐ CEHW	Clinic Site

QuantiFERON Test Ordered / /	Test Results	CXR
MR#	Verified by	Date

Follow-up Required ☐Chest X-ray ordered ☐Referred to Primary Care Provider ☐Public Health Department