



ANNUAL QUESTIONNAIRE  
FOR INDIVIDUALS WITH POSITIVE PPD SKIN HISTORY

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Date of Positive PPD exam: \_\_\_\_\_

In order to meet our clients' compliance regulations, it is required that all candidates who have positive PPD history complete this questionnaire and have it signed by their physician.

If you have a negative history it is not necessary to fill out this questionnaire.

During the past year have you experienced any of the following signs or symptoms? Please circle the appropriate response:

Chronic/persistent cough	YES	NO
Cough or spit blood	YES	NO
Unexplained significant weight loss/anorexia	YES	NO
Persistent fever above 100 deg F	YES	NO
Night sweats	YES	NO
Unexplained fatigue	YES	NO
Chest pains	YES	NO
Been advised that you are immunosuppressed for any reason	YES	NO
Loss of appetite	YES	NO
Swollen glands in neck or elsewhere	YES	NO
Recurrent/persistent kidney/bladder infections	YES	NO
Shortness of breath	YES	NO
Frequent of recurring chills	YES	NO

Persons with a positive PPD who are experiencing symptoms should receive a chest x-ray to assess for pulmonary tuberculosis

I understand the importance of seeking medical attention if I display any of the above symptoms. I will also notify my physician of any exposure to Tuberculosis.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please fax this questionnaire signed by your physician along with your CXR  
results to: 813-870-9051  
or scan and email to [credentials@missionsearchusa.com](mailto:credentials@missionsearchusa.com)**