



## ANNUAL TB QUESTIONNAIRE

Name:		DOB	
Have you ever had a positive PPD exam?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	When?

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.

During the past year have you experienced any of the following signs or symptoms? Please check the appropriate response:	YES	NO
Chronic/persistent cough	<input type="checkbox"/>	<input type="checkbox"/>
Cough or spit blood	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained significant weight loss/anorexia	<input type="checkbox"/>	<input type="checkbox"/>
Persistent fever above 100 deg F	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>
Been advised that you are immunosuppressed for any reason	<input type="checkbox"/>	<input type="checkbox"/>
Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>
Swollen glands in neck or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent/persistent kidney/bladder infections	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Frequent of recurring chills	<input type="checkbox"/>	<input type="checkbox"/>

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.

**Applicant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

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

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

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

Exam Date: \_\_\_\_\_

**Please fax this questionnaire signed by your physician  
along with your Chest X-Ray results toll free to:  
888-279-3272  
or scan and email to [credentials@missionsearchusa.com](mailto:credentials@missionsearchusa.com)**

