APPENDIX 8
SONOMA STATE UNIVERITY DEPARTMENT OF NURSING
TUBERCULOSIS SCREENING QUESTIONNAIRE

Name Date

Positive TB skin test (PPD) Date:_____

Last Chest X-Ray Date: _____

Please indicate if you are having any of the following problems for three to four weeks or longer:

1.	Chronic Cough (greater than 3 weeks)	Yes _____	No _____
2.	Production of Sputum	Yes _____	No _____
3.	Blood-Streaked Sputum	Yes _____	No_____
4.	Unexplained Weight Loss	Yes _____	No_____
5.	Fever	Yes_____	No _____
6.	Fatigue/Tiredness	Yes_____	No _____
7.	Night Sweats	Yes_____	No _____
8.	Shortness of Breath	Yes_____	No___

NO EVIDENCE OF PULMONARY TUBERCULOSIS OR CONTAGIUM.

Date_____ _____
Student Signature

Date_____ _____
HealthCare Provider