MOUNT CARMEL

EMPLOYEE HEALTH TUBERCULOSIS SCREENING QUESTIONNAIRE

MCHS Employee Health forms can be faxed to **614-234-8903** or emailed to
COCSSHAREDMBEmployeeHealth@mchs.com

Name (Print):_____ID_____Dept._____

Volunteer ☐ SS#_____ Contract ☐ SS#_____

In the past year have you experienced any of the following symptoms over a prolonged period of time (more than 2 weeks in duration)?

During the last year, have you had any of the following	No	Yes	If yes, please give details
1. Persistent cough			
2. Coughing up blood			
3. Persistent fever			
4. Excessive sweating, especially at night			
5. Excessive/unexplained weight loss			
6. Excessive fatigue			
7. Compromised immune system			
8. Frequent upper respiratory symptoms such as colds, sore throats, pneumonia			
9. Abdominal or gastrointestinal problems such as frequent diarrhea, nausea or vomiting			
10. Communicable diseases such as; hepatitis, TB			

COLLEAGUE SIGNATURE:_____ DATE: _____

EH RN SIGNATURE:_____ DATE: _____

Normal (No further F/U needed) _____ **Abnormal** (referred to Provider)_____

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