TB Self-screening Form

Name: ___________________________________ DOB: __________________________

Please indicate below if you have any of the following:

Signs and Symptoms of TB Disease **Persons who answer "yes" to any of the following signs and symptoms warrant further investigation to rule out infectious pulmonary/laryngeal TB.**	**Yes**	**No**
1. Productive cough or more than three (3) weeks duration	☐	☐
2. Coughing up blood	☐	☐
3. Persistent fevers	☐	☐
4. Drenching night sweats	☐	☐
5. Unplanned weight loss	☐	☐

This assessment was completed by (print name):____

Signature: _____________________________________ Date of assessment: ___________________

If referral is needed list the name of provider/clinic to which the person was referred:

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