Communicable Disease Questionnaire

Be Special… Make a Difference!

__________________________________________  ____________________________
Name                                      Date

Positive RB skin test (PPD) date ___________

Last Chest X-Ray date______________________  Results: ________________________

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

Are you currently experiencing?

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) Shortness of Breath                       Yes_____     No_______

__________________________________________  ____________________________
Agency Employee Signature                 Date

__________________________________________  ____________________________
Employee Health Nurse                      Date

__________________________________________  ____________________________
Physician /CRNP, PA Signature              Date
(Applicable to only those facilities who have this as a requirement)