KAISER PERMANENTE® thrive

Greater Southern Alameda Area

Name: _____

Address: _____

Subject: TUBERCULOSIS MEDICAL SURVEILLANCE

Your TB Medical Surveillance must be completed UNLESS ADVISED OTHERWISE. Failure to complete this screening may result in your being placed on administrative leave without pay until compliance is achieved. In order to meet healthcare organization accreditation and regulatory compliance requirements, all Employees, including MD's, Contracted employees, Students and Volunteers must participate in periodic TB medical screening. Your participation is mandatory and a condition of continued service. (California Division HR Policy 5.02).

	YES	NO
1. Have you ever had Tuberculosis?	_____	_____
➢ If yes, when? _____		
➢ If yes, were you medicated? _____		
2. Have you ever been in therapy to prevent TB?	_____	_____
➢ If yes, for how long? _____		
➢ What was the year? _____		
3. Have you ever been informed of an abnormal Chest X-ray?	_____	_____
4. Have you ever received BCG Vaccine?	_____	_____
(A vaccine given in foreign countries to prevent TB. It leaves a scar on your arm similar to a smallpox scar.)		
➢ If yes, what year? _____		
➢ If so, when was your last skin test? _____		
5. Have you ever had a positive TB skin test?	_____	_____
➢ If yes, when? _____		
➢ If so, where? _____		

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In the past **12-months** have you experienced the following:	YES	NO
1. Had a chronic (recurrent) cough?	_____	_____
2. Had unexplained recurrent fevers?	_____	_____
3. Had recurrent night sweats?	_____	_____
4. Coughed up or spit blood?	_____	_____
5. Had any unexplained weight loss?	_____	_____
6. Experienced unexplained chronic fatigue?	_____	_____
7. Been advised you are immunosuppressed for any reason?	_____	_____

Signature: _____ **Date:** _____

NOTE: This TB Questionnaire was sent to you because your records show that you have had a documented positive PPD skin test.