Annual Health and TB Risk Assessment

(To be completed by employee or volunteer both pages)

Name (Last) (First) (Mid)	Employee ID Number	Job Title	Work/Cell Phone No.
Home Address: (street/Apt. No.) (City) (St) (Zip)		Home Phone No.	

1. How would you describe your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

2. In the past 12 months have you had:

- Any Serious Illness? ☐ Yes ☐ No
- Any Infectious disease? ☐ Yes ☐ No
- Exposure to any communicable disease (such as tuberculosis, etc)? ☐ Yes ☐ No

If you answered yes to any of the above, please list illness(es), disease(s) and/or exposures(s)

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3. In the past 12 months, have you been treated by a health care provider? ☐ Yes ☐ No

If yes, please explain:

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4. Are there any factors affecting your health which would place patients, their families or fellow employees at risk or which would Interfere with the performance of your job duties?
(These factors Include, but are not limited to, habituation or active addiction to alcohol, depressants, stimulants, narcotics or other substances that may alter your behavior.)

☐ Yes ☐ No

If yes, please describe:

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5. Do you take any prescription drugs or medications regularly?

☐ Yes ☐ No

If yes, please describe usage, Including dosage, frequency and purpose.

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Annual Tuberculosis (TB) Risk Assessment

1. Since your last TB test, have you spent more than 30 days in a country with elevated TB rate (includes all countries except United States, Canada, Australia, New Zealand, and those in Northern or Western Europe)?

O No O Yes, I have spent more than 30 days in a foreign country AND I haven't been tested for TB since I returned.

2. Do you have a weakened immune system for any reason including organ transplant, HIV infection, treatment with immunosuppressive medication (e.g. TNF-alpha antagonist (infliximab, etanercept), chronic steroids (prednisone >15mg/day for >1 month)).

O No O Yes, one or more of these is true for me

3. Since your last TB assessment, have you had close contact with anyone who had active TB disease?

O No O Yes, list date and place of your contact with a person with active TB disease:

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4. Since last assessment, have you experienced any of the following symptoms that can be symptoms of TB?

a. Coughing for 3 or more weeks	O No	O Yes
b. Coughing up blood	O No	O Yes
c. Persistent shortness of breath	O No	O Yes
d. Unexplained fever, chills, or night sweats	O No	O Yes
e. Unexplained weight loss	O No	O Yes
f. Feeling tired and weak for 3 or more weeks for no known reason	O No	O Yes
g. Chest pain for no known reason	O No	O Yes

If yes, describe:

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IMPORTANT: If you answered yes and currently have any of the symptoms listed above, submit this assessment and immediately notify Employee Health and your health care provider. If you do not know how to contact Employee Health, ask your supervisor.

5. Have you been diagnosed with tuberculosis infection or TB disease or had a positive TB skin test or blood test?

O No O Yes, I had a positive TB test or TB infection
Complete "Tuberculosis Risk Assessment for Positive TB Test"

Employee Signature:	Date:
Health Services Signature:	Date:

Comments: