SAN MATEO MEDICAL CENTER Employee Health Services

ANNUAL HEALTH SCREENING AND TUBERCULOSIS SURVEILLANCE

1) Name 2) Date of birth: / / 3) Male or female

please print mo day

4) Employee ID # 5) Dept Name & org # 6) Dept phone #

7) In the past year, have you had any of the following for more than 2 weeks at a time?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Yes No |  | Yes No |  | |
| cough |   | unplanned weight loss / loss of appetite |   |  |  |
| fever fatigue |      | night sweats coughing up blood |      |  |  |

If yes to any of the above, please provide explanation:\_

8) Have you been told by a health practitioner that your immune system is suppressed or compromised? (This may affect the result of your test).  no  yes

9) In the past year, have you been in contact with any patients who are contagious for TB?

 no  yes  don't know

10) In the past year, have you been in contact with any of your own family members who are contagious for TB?

 no  yes  don't know

11) Have you been told you have a positive skin test?  no  yes  don't know

12) Have you ever had BCG?  no  yes  don't know

13) Date of last PPD skin test: Result:

14) Date of last Quantiferon: Result:

Signature: Date

**DO NOT WRITE BELOW THIS LINE - TO BE COMPLETED BY IC / EH**

 Has a history of a positive TB skin test  History of BCG

 Has symptoms  No symptoms

 Follow-up required  Referred to RM or personal MD

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Person Who | Date Applied | Site |  | Date Read | MM | Person Who |
| Applied Skin Test  PPD #1 | mo/day/year  / / | RA/LA | Lot # | mo/day/year  / / | Induration | Read Results |
| PPD #2 | / / |  |  | / / |  |  |

CXR required:  No  Yes Date: / / Results: Sent for further evaluation?  No  Yes Where: Comments:

Signed: IC/EH, date:

Revised 10/11/13