MASTER STAFFING, INC.

TB QUESTIONNAIRE

A physical examination is required on persons working in the health care field by the state law on Title XXII of the State of California.

PERSONAL INFORMATION

Last Name _____ First Name _____ Middle Name/Initial _____

Social Security # _____ Date of Birth _____

TUBERCULOSIS

Chest X-Ray is required if the TB skin test is positive or indicated by PMD or symptomatic for convertors

Date of last TB Skin Test (PPD) ☐ Positive ☐ Negative Induction _____ Date Given _____ Date Read _____

Date of Chest X-Ray* ☐ Positive ☐ Negative

***Attach lab results of Chest X-Ray and TB Questionnaire**

Please answer YES or NO if any of the following symptoms apply to you:

Loss of weight (more than 10% of body weight)	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No
Fever lasting several weeks	☐ Yes	☐ No
Frequent Coughing	☐ Yes	☐ No
Coughing blood-streaked sputum	☐ Yes	☐ No
Unusual tiredness or weakness lasting weeks	☐ Yes	☐ No
Pain in chest when taking a breath	☐ Yes	☐ No
Recent diagnosis of diabetes, silicosis, or HIV	☐ Yes	☐ No
Recent exposure to a family member or others with active TB	☐ Yes	☐ No

Please explain: _____

If you have answered YES to any of the above, are you currently being treated by a physician? ☐ Yes ☐ No

Please explain: _____

History of BCG administration _____

Birth Country _____ # Years in the U.S.A. _____

Recent travel since last PPD? _____

Employee's Signature _____ Date _____

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