Health and Human Services
Public Health

Tuberculosis Program

Healthcare Workers TB Sign and Symptom Screening

Name: ______________________________ Date of Birth: ____________

Signs and Symptoms of TB Disease Persons who answer “yes” to any of the following signs and symptoms warrant further investigation to rule out active infectious pulmonary/laryngeal TB.	YES	NO
1. Productive cough of more than three (3) weeks duration	☐	☐
2. Coughing up blood	☐	☐
3. Persistent fevers	☐	☐
4. Drenching night sweats	☐	☐
5. Unplanned weight loss	☐	☐

Person Completing the Assessment (print name): ______________________________

Signature: ______________________________ Date of Assessment: ____________

If referral is needed list the name of provider/clinic to which the person was referred:

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April 2025