CHRISTUS SANTA ROSA Health Care

Occupational Health Office
Annual Health Review and Tuberculosis Screening

Location: ___CH ___MC ___NB ___WH

Name:_____ Dept._____ ID#/SSN:_____ Date:_____

Have you ever had a **positive** TB skin Test?	☐ Y ☐ N
IF yes, do you have documentation of a positive TB Test?	☐ Y ☐ N
Have you been vaccinated with BCG, which is is a vaccination for TB, you may have received if you were born in another country.	☐ Y ☐ N ☐ Unsure
Are you presently taking any immunosuppressants?	☐ Y ☐ N
If yes, what drug and dosage?_____	
Are you pregnant?	☐ Y ☐ N ☐ N/A
Have you ever had a reaction to an immunization?	☐ Y ☐ N
Are you allergic to TB skin test solution or had an ulcer at the test site?	☐ Y ☐ N
Have you received an immunization within the last 30 days? (Not including TB Test.)	☐ Y ☐ N
Have you been sick within the last 30 days? (more than a cold or allergies)	☐ Y ☐ N

TB Questionnaire: Do you currently have any of the following?

Unexplained fever? ☐ Yes ☐ No **Night Sweats?** ☐ Yes ☐ No **Chest Pain?** ☐ Yes ☐ No **Weight Loss without dieting?** ☐ Yes ☐ No
Fatigue? ☐ Yes ☐ No **Loss of appetite?** ☐ Yes ☐ No **Bloody Sputum?** ☐ Yes ☐ No **Hoarseness?** ☐ Yes ☐ No
Cough over 3 week duration? ☐ Yes ☐ No Please explain any questions you have answered "yes" to: _____

I certify that I do not have any of the above symptoms and I believe I am not infectious for Tuberculosis. If I should develop any of these symptoms, I will contact the Occupational Health nurse immediately. I understand that completion of a screening for TB is required for continued employment with CHRISTUS Santa Rosa Health Care. I understand that this screening will be completed at the time of hire and at least annually thereafter.

_____ Signature

_____ Date

ANNUAL HEALTH REVIEW:

Have you been treated for any health conditions in the past year? ☐ Yes ☐ No If yes, what?_____
Any new conditions newly diagnosed in the past year? _____
How have your health conditions affected your ability to do your job? _____

OFFICE USE ONLY **Lot #**_____ **Expiration Date:**_____

2-Step ☐ **Needs 2-Step** ☐ **Annual** ☐ **No 2-Step Needed** ☐ **Non Staff** ☐ **New Hire** ☐
Initial Post-Exposure ☐ **House Supervisor to Read** ☐ **12-Week Exposure** ☐

Date Administered:_____ Right / Left Forearm Administered by: _____
Read By:_____ Date:_____ Results:_____
Comment: _____