

**TALBOT COUNTY HEALTH DEPARTMENT**  
**EMPLOYEE ANNUAL TB SYMPTOM CHECKLIST**

Employee Name \_\_\_\_\_

Department \_\_\_\_\_

Date \_\_\_\_\_

Please answer each question and return to Employee Health when complete.

- |  |     |    |
|--|-----|----|
| 1. Have you knowingly been exposed to TB in the past year? | Yes | No |
| 2. Cough for more than 3 weeks?                            | Yes | No |
| 3. Coughing up blood?                                      | Yes | No |
| 4. Unexplained fever?                                      | Yes | No |
| 5. Unexplained night Sweats?                               | Yes | No |
| 6. Unexplained weight loss/poor appetite?                  | Yes | No |
| 7. Chest pain or shortness of breath?                      | Yes | No |
| 8. Unexplained tiredness?                                  | Yes | No |

I consent to the above screening. I understand if I should develop any of the above symptoms, I should consult with my primary care physician and Employee Health Program staff.

\_\_\_\_\_

Employee Signature      Date

\_\_\_\_\_

Nurse Signature      Date