OKLAHOMA DEPARTMENT OF CORRECTIONS

Tuberculosis Questionnaire

This questionnaire will help identify changes in your health status as it relates to tuberculosis.

TST date: _____ Result: _____mm TST is ___Positive ___Negative
CXR date: _____ Where CXR was taken: _____

Symptoms	YES	NO	COMMENTS
1. Unresolving cough lasting more than 3 weeks?			
A. With hemoptysis (blood)?			
B. With sputum (phlegm)? Describe:			
2. Unexplained weight loss?			
A. Number of pounds lost			
B. Stated weight			
C. Actual weight			
3. Drenching night sweats?			
A. How long?			
4. Fever or chills?			
A. How long?			
5. Fatigue?			
A. How long?			
6. Have you taken medicine for TB?			
A. When?			
B. Where?			
C. Did you complete your treatment?			
7. Have you been exposed to active TB?			
A. When?			
B. Where?			
C. Name of person.			

Consider for ISOLATION (inmates) or referral to local health department/private physician (employees) if:

- **#1A = YES**
- **#1 + #2 or #3 = YES**

This inmate was isolated in room _____, on _____ at _____.

Evaluator's Signature _____ Date: _____

Work Location (employee only) _____

Employee Name (Print) _____Employee ID _____

Inmate Name (Print) _____ODOC # _____