



Annual TB Risk Assessment Questionnaire for Non-Employees

Name: _____ Date of Birth: _____

Date form completed: _____ Phone Number: _____

Instructions: Please answer the following questions **while thinking of the past year**. This is a confidential medical evaluation. Based on your responses you may be contacted by an EHS nurse.

| | No | Yes |
|--|----|--|
| 1. Do you have a history of a positive TB skin test, positive IGRA (TB Blood test) or had TB disease? | | Do not fill out this form. You need to complete the Annual Questionnaire for Non-Employees with a History of a Positive TB Test . |
| | No | Yes, please describe: |
| 2. I have a persistent cough lasting 3 or more weeks AND one or more of the following symptoms: unexplained weight loss, sweating at night that soaks your clothing, fever, weakness or feeling tired all the time. | | |
| 3. I have been exposed to someone with known active TB disease or lived with/had close contact with someone who has known active TB disease. | | |
| 4. I have traveled to a country with a high rate of TB for more than one month. * *any country except the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe. | | |
| 5. I am a current resident or have lived in a state with a high rate of TB.* *Alaska, California, Florida, Hawaii, New Jersey, New York, Texas and/or Washington DC | | |
| 6. I have worked or volunteered in a setting at high-risk for TB.* *healthcare facilities, correctional institutions, homeless shelters, mental health institutions, or other long term residential facility in Alaska, California, Florida, Hawaii, New Jersey, New York, Texas and/or Washington D.C. | | |

My responses on this form are true and correct to the best of my knowledge.

Non-Employee Signature

Date

Return completed and signed form to:

Employee Health Services

700 University Bay Drive, Suite 101 Madison, WI 53705

P: (608) 264-7535 Fax: (608) 262-7284

hremployehealth@uwhealth.org

Clinic Hours: M-F; 7am – 4pm