



City Pro Group, Inc.

Early Intervention Agency and CPSE

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ANNUAL TUBERCULOSIS SCREENING QUESTIONANARIE

Employee Name: _____

SS# _____

Address _____

Have you ever had a test for Tuberculosis? Yes _____ No _____

PPD/ Mantoux Date _____ Result _____

Chest X-Ray Date _____ Result _____

Treatment Type _____

Dates of Treatment _____

Do you have any of the following symptoms?

Symptoms	Yes	No	Comments
Weakness	_____	_____	_____
Fatigue	_____	_____	_____
Lack of Appetite	_____	_____	_____
Weight Loss	_____	_____	_____
Low Grade Fever	_____	_____	_____
Night Sweats	_____	_____	_____
Flu- Like Symptoms	_____	_____	_____
Chest Pain	_____	_____	_____
Shortness of Breath	_____	_____	_____
Persistent of Cough	_____	_____	_____
Blood Streaked Sputum	_____	_____	_____
Color of Sputum (CIRCLE)	Clear	Yellow	Other: _____

Have you ever been exposed to anyone exhibiting the above signs or symptoms, or someone who has active tuberculosis? Yes _____ No _____

If yes, when and whom were you exposed, what type, if any, follow up treatment did you receive?

If I should notice any of the signs or symptoms, I understand that I am to immediately notify my Physician and my Employer.

Physician Signature

Date