WRIGHT STATE UNIVERSITY

Wright State University-Miami Valley
College of Nursing and Health
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Dayton, OH 45435-0001
(937) 775-3131

ANNUAL TUBERCULOSIS CONTROL CLINICAL QUESTIONNAIRE
(for positive responders)

Name: _____

Date: _____ UID _____

1. Have you had any unexplained change in your respiratory status:
    a. Any unexplained cough lasting three or more weeks that may produce discolored or bloody sputum. Yes No
    b. Shortness of breath Yes No
    c. Chest pain Yes No
    d. Pain with breathing or coughing (pleurisy) Yes No
2. Unintended weight loss Yes No
3. Any unexplained loss of appetite Yes No
4. Any unexplained fatigue Yes No
5. Any unexplained fever Yes No
6. Any unexplained night sweats Yes No
7. Any unexplained chills Yes No
8. Any other unexplained changes in personal health status Yes No
    (If yes, please explain).

Explanation/Comments:

_____ _____

Signature of Patient

Physician or Nurse Practitioner
(Please print or stamp.)

3/10/09