

# 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: _____
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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 # \_\_\_\_\_