ANNUAL CONSUMER TUBERCULOSIS HEALTH QUESTIONNAIRE

Consumer or Parent / Guardian Must Complete All Sections

Consumer Name: ____________________________ Date of Birth: _____________________

Do you have any of the following Symptoms?	**YES**	**NO**
Productive cough for greater than 3 weeks	( )	( )
Persistent weight loss (without dieting)	( )	( )
Persistent low grade fever	( )	( )
Night Sweats	( )	( )
Loss of appetite	( )	( )
Coughing up blood	( )	( )
Shortness of breath	( )	( )
Chest Pain	( )	( )

If you marked yes to any of the above symptoms, please comment: __________________

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___________________________________ ___________________________

Client's Signature Date

If consumer is unable to sign, a parent or Authorized Personal Representative must sign below:

___________________________________ ___________________________

Signature of Parent or Authorized Personal Representative Date

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