2024 Annual Tuberculosis (TB) Risk Assessment Questionnaire for Employees

COLORADO
Department of Public Health & Environment

Last name	First name		MI
Address	City	State	Zip
Phone	Date of Birth	Country of Birth	

1. **Have you traveled outside the U.S. since your last risk assessment?** No ☐ Yes ☐

   If yes, list countries, duration of visits, and purpose of travel

2. **Have you been diagnosed with any of the following conditions that may impair your immune system?**

   No ☐ Yes ☐

Chronic steroid use	Gastrectomy/intestinal bypass	Diabetes mellitus
HIV infection	Crohn's disease	Dialysis/Renal failure
Cancer of the head or neck	Rheumatoid arthritis	Chronic malabsorption syndromes
Silicosis	Use of TNF-α antagonist	Low body weight (10% or more below ideal)
Leukemia, lymphoma or Hodgkin's disease		

3. **Have you ever resided, worked or volunteered in any of the following facilities?**

   No ☐ Yes ☐ If yes, check all that apply

☐ Prison	☐ Hospital	☐ Nursing home
☐ Homeless shelter	☐ Other long term treatment center	

4. **Do you currently have any of the following symptoms?** No ☐ Yes ☐ If yes, check all that apply

☐ Cough ≥ 3 weeks	☐ Unexplained fever	☐ Chest pain	☐ Chills
☐ Productive cough (coughing something)	☐ Night sweats	☐ Respiratory difficulty (shortness of breath)	☐ Loss of appetite
☐ Coughing up blood	☐ Unexplained weight loss	☐ Fatigue	☐ Weakness

5. **Have you ever had contact with a person known to have active tuberculosis?** No ☐ Yes ☐

6. **Have you ever had an abnormal chest X-ray?** ☐ No ☐ Yes

8. **Have you had a tuberculin skin test or IGRA blood test before?** ☑ Yes ☐ No

   If yes, list where given ON FILE Date UPON HIRE

   If yes, provide documentation (attach results)

9. If the test result was positive, did you take TB medications? No ☐ Yes ☐

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a. If you took TB medication(s), what did you take?

Name of TB medication Don't know ☐

b. Where were you treated?
(city, state, country, doctor's contact information)

c. What year did you start treatment?

d. How long did you take this medication?

The information above is true and complete to the best of my knowledge, and I am aware that deliberate misrepresentation may jeopardize my health. I understand that this information is confidential and will not be released without my knowledge and written permission.

Employee signature Date

FOR INTERNAL USE ONLY

Name of sender Title

Facility name

Phone number Secure Fax

Address State Zip

Sender signature **Date referral sent**

Referred to:

☐ PCP ☐ Urgent Care ☐ ED ☐ Employee Health ☐ Other

Name of person/facility

Address

☐ Fax ☐ phone call

Reason for Referral

Requested follow-up

☐ TST/PPD ☐ IGRA ☐ CXR ☐ CT ☐ Medical Evaluation ☐ 3 Sputum for Acid Fast Bacilli

Other