CITY OF
LONG BEACH

TB Symptom Questionnaire

Instructions for Shelter Staff:

The purpose of this form is to help identify clients who **may** have infectious TB. Please complete this form as part of the initial intake process if (1) a client reports they have a persistent cough, (2) if shelter staff sees that the client is coughing or (3) if during annual review, shelter staff notes a client has a cough that has lasted for more than 3 weeks.

HISTORY/SYMPTOMS	Yes	No
Do you have a cough that has lasted for 3 weeks or more?		
1. Have you lost weight without explanation during the past month?		
2. Have you sweated so much during the night that you've soaked your sheets or clothing, during the past month?		
3. Have you coughed up blood in the past month?		
4. Have you been more tired than usual over the past month?		
5. Have you had fevers almost daily for more than one week?		

Does the client have a cough that has lasted 3 weeks or more **AND** has answered "yes" to at least one other question above? ☐ Yes ☐ No

If you marked "YES" above, immediately refer the client for a medical evaluation.

Exposure Control Methods Initiated:

- Give the client a mask to wear: ☐ Don
- Instruct the client to cover their nose and mouth when coughing or sneezing: ☐ Don
- Separate the client from others and place in a well-ventilated room: ☐ Don
- Initiate medical evaluation protocols and transportation: ☐ Don

Comments____

Client Name: ____________________ Arrival Date: ____________________

Shelter Name: ____________________ Shelter Phone : ____________________

Shelter Address: ____

Evaluator Name: ____

Date: ____________________