NEW BEDFORD BOARD OF HEALTH
TUBERCULOSIS SYMPTOM SCREENING QUESTIONNAIRE

This form is to be used for persons who are required to have TB symptom screening as a component of the body art application with the New Bedford Health Department and have previously received a positive tuberculosis test.

In the past 12 months have you experienced any of the following symptoms?

a)	Cough lasting 3 weeks or longer	☐ YES ☐ NO
b)	Coughing up blood or sputum	☐ YES ☐ NO
c)	Unexplained weakness or fatigue	☐ YES ☐ NO
d)	Unexplained chest pain	☐ YES ☐ NO
e)	Unexplained weight loss or loss of appetite	☐ YES ☐ NO
f)	Fever, chills, or night sweats for unknown reason	☐ YES ☐ NO

Applicant Name (print): _____

Applicant Signature: _____

Date: _____