Job Shadow Questionnaire
For Signs and Symptoms of Potential Communicable Diseases

Name: ____ Date of Birth: _________________________

If under 18, please have parent or guardian fill out the chart below.

Please complete each question below:	Yes	No	Unsure
1. Do you have a persistent cough? (i.e., a cough lasting longer than 3 weeks?)			
2. Do you have night sweats?			
3. Have you had significant weight loss (10 lbs.) in the last 3 weeks?			
4. Have you had unexplained fever in the last 3 weeks?			
5. Do you have a lack of appetite?			
6. Are you coughing up bloody sputum?			
7. Have you had contact with someone that has Tuberculosis?			
8. Have you had a positive mantoux tuberculosis skin test in the past?			
9. Do you have diarrhea?			
10. Do you have a skin rash?			
11. Do you have any eye drainage?			
12. Have you had chicken pox? Please list vaccination dates:			
13. Have you had measles? Please list dose dates of vaccination(s):			
14. Have you had German measles (rubella)? Please list dose dates of vaccinations(s):			
15. Have you had mumps? Please list dose dates of vaccinations(s):			

Signature : ____ Date: _________________________

If under 18, please have parent or guardian fill out the following information:

Name: ____ Relationship: _________________________

Signature: ____ Date: _________________________