



**Job Shadow Health Questionnaire**  
 For Signs and Symptoms of Potential Communicable Diseases

Name: \_\_\_\_\_

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

<b>Please complete each question below</b>	<b>Yes</b>	<b>No</b>	<b>Unsure</b>
Do you have a persistent cough? (i.e. a cough lasting longer than three weeks?)			
Do you have night sweats?			
Have you had significant weight loss (10 lbs.) in the last three weeks?			
Have you had unexplained fever in the last three weeks?			
Do you have a lack of appetite?			
Are you coughing up bloody sputum (mucus)?			
Have you had contact with someone that has Tuberculosis?			
Have you had a positive Mantoux tuberculosis skin test in the past?			
Do you have diarrhea?			
Do you have a skin rash?			
Do you have any eye drainage?			
Have you ever had chicken pox?			
Have you ever had measles?			
Have you ever had German measles (rubella)?			
Have you ever had mumps?			

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

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

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_