New Jersey Department of Health

Symptom Assessment for Pulmonary Tuberculosis (TB)

Name *(Last, First, MI)*		Birthdate *(mm/dd/yyyy)*
Street Address		Telephone Number
City	State	Zip Code

Date of Symptom Assessment *(mm/dd/yyyy)*

TB-Like Symptoms *(Check all that apply)*:

- ☐ Productive Cough of Undiagnosed Cause (more than 3 weeks in duration)
- ☐ Coughing Up Blood (Hemoptysis)
- ☐ Unexplained Weight Loss (10 pounds or greater without dieting)
- ☐ Night Sweats (regardless of room temperature)
- ☐ Unexplained Loss of Appetite
- ☐ Very Easily Tired (Fatigability)
- ☐ Fever
- ☐ Chills
- ☐ Chest Pain

If any symptoms are reported a chest radiograph and medical evaluation is needed.

☐ **No TB-Like Symptoms Reported or Observed**

Name of Licensed MD/RN *(Print)*	
Signature of Licensed MD/RN	Date