

**TB SCREENING QUESTIONNAIRE**

**(History of Positive Tuberculin Skin Test)**

**Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Since your last TB screening, have you lived with or had close contact with someone who has active TB disease?**

## YES 🞏 NO 🞏

1. **Since your last TB screening, have you had an abnormal chest x-ray?**

## YES 🞏 NO 🞏

1. **Since your last TB screening, have you traveled outside the U.S.A.?**

## YES 🞏 NO 🞏

1. **Do you have any of the following conditions:** (Circle all that apply)

High dose cortisone, rheumatoid arthritis, immunocompromised, HIV, cancer, diabetes, chemotherapy, end stage kidney disease, gastrectomy (partial or full removal of stomach), severe emphysema or chronic bronchitis (COPD), any other serious medical condition that might lower resistance to infections, history of drug or alcohol problems, malabsorption syndrome (including anorexia).

1. **Since your last TB skin test, have you had any of the following symptoms for more than 3 weeks**

Persistent cough? Yes [ ] No [ ]

Hoarseness? Yes [ ] No [ ]

Coughing up blood? Yes [ ] No [ ]

Excessive Night Sweats? Yes [ ] No [ ]

Persistent Fever? Yes [ ] No [ ]

Undue Fatigue? Yes [ ] No [ ]

Unintentional Weight Loss? Yes [ ] No [ ]

 **If you any YES to any item in question 5, a chest x-ray is required.**

Student signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have reviewed the TB Screening questionnaire and have determined this student to be free of active tuberculosis at this time.

Provider signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_