Annual Tuberculosis Screening Questionnaire

Student’s Name: __________________________________________________________
(Print): Last/Family First MI
Student ID#/B0#: ____________________________ Date: __________________________

Please answer the following questions: Entry Term and Year___________________________

1. Have you ever had a positive TB skin test? _______ If yes, how many millimeters was your positive PPD (if known)? ______ Date: __________________________

2. Have you ever taken the BCG vaccine? ............................................................................................ Y / N

3. When was your last Chest X-Ray (CXR) taken? ________________________________________________

4. If history of positive PPD, did you successfully complete 6-9 months of INH (or similar) chemoprophylaxis therapy? ...... Y / N

5. If yes, where and when? Dates? _____________________________________________________________

6. If no, reason for not taking INH protocol _______________________________________________________________________________________

7. Have you ever experienced any of the following symptoms within the past year?
   a. Persistent productive cough? ................................................................. Y / N
   b. Coughing up blood? ................................................................. Y / N
   c. Chest pain? ................................................................. Y / N
   d. Shortness of breath/difficulty breathing? ................................................................. Y / N
   e. Unexplained fever lasting more than 3 days? ................................................................. Y / N
   f. Unexplained night sweats? ................................................................. Y / N
   g. Unexplained sudden weight loss? ................................................................. Y / N
   h. Unexplained fatigue/run down feeling? ................................................................. Y / N

8. Have you sought medical care for chest symptoms within the past year? ................................................................. Y / N

9. Have you ever had a positive HIV test? ................................................................. Y / N

10. Have you ever used illegal intravenous drugs? ................................................................. Y / N

11. Have you ever lived with or been in close contact with someone who had TB disease? ................................................................. Y / N

12. Considering the list of countries/continents below:
   a. Africa
   b. Asia: China, Mongolia, Vietnam, Korea, Indonesia, India, Pakistan, Bangladesh
   c. Eastern Europe: Russia and former Soviet Union States, Armenia
d. **Latin America**: Mexico, Guatemala, South America

e. **Caribbean Islands**: Jamaica, Dominican Republic, Haiti, Cuba, Trinidad & Tobago

f. **Pacific Islands including the Philippines**: excluding Hawaii

    f.i.1. Were you born in one of these countries?

    f.i.2. Have you ever stayed in one of these places for 2 weeks or longer?

    f.i.3. Have you lived with or been in close contact with someone who stayed or lived in one of these countries for 2 weeks or longer?

If you answered yes to any of the above questions, please explain:

________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________

I certify that the information contained on this TB Questionnaire is true and accurate. I hereby understand that if any of the above responses are “yes” that I will be re-evaluated by a Student Health Provider to rule out the presence of active tuberculosis. Furthermore, I may be required to have a current chest film done and lab testing to obtain medical clearance.

Student/Patient Signature  ________________________________  Date: ______________

Health Care Provider Signature:  ________________________________  Date: ______________