UCF Health Services

University of Central Florida College of Medicine

Tuberculosis Screening Questionnaire

Please complete the following information **if** you have a history of a **POSITIVE** TB Skin Test:

Name: _____ _____ _____ Male ❒ Female ❒
Last First Initial

Have you ever received BCG?	Yes ☐ No ☐	If Yes, date of BCG:_____
Date of last PPD Skin Test:		_____/_____/_____
Did you take any medication associated with a positive TB Skin Test?	Yes ☐ No ☐	If Yes, dates:_____
Date of last chest X-Ray:		_____/_____/_____

Please check (✓) if you are having any of the following **unexplained** symptoms for three to four weeks or longer:

Unexplained fatigue	❒ Yes	❒ No	Night sweats (drenching)	❒ Yes	❒ No
Unexplained weight loss	❒ Yes	❒ No	Persistent cough	❒ Yes	❒ No
Loss of appetite	❒ Yes	❒ No	Spitting/Coughing up blood	❒ Yes	❒ No
Fever (usually at night)	❒ Yes	❒ No	Chest pain	❒ Yes	❒ No

Health Care Provider Certification

HEALTH CARE PROVIDER CERTIFICATION AND ADDRESS

_____
Printed Name

_____
Practice Name

_____
Street

_____
City, State, Zip Code

_____ _____
Signature *Date*

An official stamp from a doctor's office, clinic or health department must appear here or on the official document(s) attached or this form will not be approved.

RETURN ALL DOCUMENTATION TO:
Office of Student Affairs
UCF College of Medicine
Health Sciences Campus at Lake Nona
6850 Lake Nona Boulevard, Suite 115
Orlando, Florida 32827
(407) 266-1353
FAX: (407) 266-1389

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