**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?  Date of last PPD Skin Test:  Did you take any medication associated with a positive TB Skin Test?  Date of last chest X-Ray: | Yes 🞏 No 🞏  Yes 🞏 No 🞏 | If Yes, date of BCG:  / /  If Yes, dates:  / / |

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**

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