UCF Health Services

UCF 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.

UPLOAD THIS DOCUMENT TO IMMUNITRAX.
DO NOT SEND IT TO STUDENT AFFAIRS.

Updated 1/2023