

Tuberculosis Screening Questionnaire

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

Name: _____	_____	_____	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Last	First	Initial		

Have you ever received BCG?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If Yes, date of BCG: _____
Date of last PPD Skin Test:			_____/_____/_____
Did you take any medication associated with a positive TB Skin Test?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	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 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Night sweats (drenching) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Unexplained weight loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Persistent cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Loss of appetite | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Spitting/Coughing up blood | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fever (usually at night) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Chest pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Health Care Provider Certification

HEALTH CARE PROVIDER CERTIFICATION AND ADDRESS	
_____ <i>Printed Name</i>	
_____ <i>Practice Name</i>	
_____ <i>Street</i>	
_____ <i>City, State, Zip Code</i>	
_____ <i>Signature</i>	_____ <i>Date</i>
<i>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.</i>	

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