



Form: C Initial TB Screen & Symptom Survey

Student completes the questionnaire. Must be reviewed and signed by the provider

Name \_\_\_\_\_ DOB: \_\_\_\_\_ Program/ Graduation Yr. \_\_\_\_\_
Please Print

Initial TB Screen & History

- 1. Were you ever told you had a positive PPD skin test? If yes, enter the date \_\_\_\_\_ and size in \_\_\_\_\_ mm induration.
2. Can you provide a document your provider with the date and size of the PPD?
3. Were you born in another country? If yes, where and when \_\_\_\_\_
4. Did you ever get a BCG vaccine? If yes, when? \_\_\_\_\_
5. Have you ever had a IGRA blood test such as a TB quantiFERON gold or T-spot? If yes, when \_\_\_\_\_ Was the test result pos neg or indeterminate
6. Have you ever been told you had latent TB infection (LTBI)?
7. Have you ever taken INH or any other anti TB medication? If yes, name of medication (s) \_\_\_\_\_ Date started \_\_\_\_\_ Date ended \_\_\_\_\_
8. Can you provide documentation of having treatment with anti TB medication?
9. Have you ever traveled outside of the country for a month or longer? If yes, Where and when \_\_\_\_\_
10. Has a family member, close friend or roommate ever been treated for tuberculosis?
11. Have you ever lived, worked or volunteered in a residential setting, shelter or hospital? If yes, where and when \_\_\_\_\_

Symptom Survey

The Symptom Survey is required annually for anyone with a current or past positive PPD.

During the past year have you had any of the following symptoms?

- Unexplained weight loss? Yes No Date of last CXR: \_\_\_\_\_ pos neg
Decrease in appetite? Yes No
Persistent cough? Yes No
Blood streaked sputum? Yes No Date of last QFT: \_\_\_\_\_ pos neg
Night Sweats? Yes No
Unexplained low grade fever? Yes No
Swelling of the lymph nodes? Yes No
Unusual tiredness or fatigue? Yes No

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Providers Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider's name

Providers address or stamp: